FAYETTEVILLE CITY SCHOOL SYSTEM

R.A.S. F.M.S. F. H.S.
Fayetteville, Tennessee 37334

PRESCRIPTION MEDICATION PERMISSION FORM
TO BE FILLED OUT BY HEALTHCARE PROVIDER OFFICE

School (Circle): RAS FMS FHS

Student: _____ Date: _____

Physician: Is it NECESSARY that medication MUST be self-administered DURING SCHOOL HOURS? Please Circle Y N

If Inhaler: Do you authorize self-possession of inhaler while at school? Y N NA

Fayetteville City School System may suspend or revoke the student's possession and self-administration privileges, if student misuses inhaler or makes inhaler available for usage by another student. Medical

Condition: _____

Medication: _____ Dosage: _____

When Give? _____ Do not exceed _____ doses at school.

How Often? _____ Duration? _____

Possible Side Effects of Med: _____

Physician: _____ _____

Printed Name Physician Signature

Healthcare Office Stamp:

It is solely understood that assistance in self-administration is given to the student solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of acceptance of the request to perform this service by any person employed by the Fayetteville City School System, the undersigned parent/guardian hereby agrees to release the Fayetteville City School System and its personnel from legal claim, which they now have or may thereafter have arising out of any employee's assistance in a student's self-administration of medication. I, hereby, authorize for my child to self-administer the medication above listed while at school.

Date: _____ Parent/Guardian Sign: _____

MEDICATION MUST BE IN ORIGINAL PHARMACY LABELED CONTAINER.

FAYETTEVILLE CITY SCHOOL SYSTEM
Fayetteville, Tennessee

OVER-THE-COUNTER MEDICATIONS (OTC)
PERMISSION FORMS FOR SHORT TERM USAGE

Student: _____ School: RAS FMS FHS

Medication: Children's Jr. Adult

Tylenol Motrin Advil Other: _____

Dosage: _____ teaspoon(s). 1 tablet 2 tablets 3 tablets 4 tablets

Time: _____ Not to exceed _____doses per school day.

Reason medication is to be taken: _____

Date medication is to be discontinued and picked up by parent/guardian at school: _____

Common side effects of OTC: (Tylenol, Motrin, Advil) are headaches, dizziness, drowsiness, fatigue, nausea, vomiting, diarrhea, dry mouth, rash)

Other Side Effects:_____

It is understood that assistance in self-administration is given to the student solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by any person employed by the Fayetteville City School System, the undersigned parent or guardian hereby agrees to release the Fayetteville City School System and its personnel from legal claim, which they now have or may thereafter have, arising out of any employee's assistance in a student's self-administration of medication.

I hereby give my permission for the above-listed student to self-administer the above listed OTC medications. I understand that if I send this medication to school for my child to take, it WILL BE SENT IN THE ORIGINAL BOTTLE WITH MY CHILD'S NAME WRITTEN ON THE CONTAINER.

Date: _____ _____
Signature of Parent or Guardian

(____)_____-_____ _____
Phone Number

_____
Current Address

FAYETTEVILLE CITY SCHOOLS HEALTH SERVICES *Confidential*
HEALTH HISTORY

THIS FORM MUST BE COMPLETED BY A PARENT OR GUARDIAN

Dear Parents/Guardians,

Please complete the information on your child's health history. This information is needed in order that we may give your child the best possible care in the event of an illness or emergency. If your child does have a health condition/concern PLEASE give detailed information about what is needed to give your child the best possible care.

Student Name_____ Grade/Teacher_____
first middle last
Date of Birth_____ Age_____ Sex M or F Physician_____
Legal Guardian_____
Address_____
Father's Name_____ Father's Home Phone_____
Father's Work Phone_____ Father's Cell Phone_____

Mother's Name_____ Mother's Home Phone_____
Mother's Work Phone_____ Mother's Cell Phone_____

Brothers and sisters at school (names and homerooms)_____

ATTEMPTS WILL BE MADE TO CONTACT A PARENT FIRST IN CASE OF ILLNESS OR EMERGENCY. IF A PARENT CANNOT BE REACHED, PLEASE LIST EMERGENCY CONTACTS IN THE ORDER YOU WISH FOR THEM TO BE CONTACTED.

1. Name_____ Phone_____ Relationship_____

2. Name_____ Phone_____ Relationship_____

3. Name_____ Phone_____ Relationship_____

HEALTH INFORMATION

1. Is student under medical treatment at this time? Yes_____ No _____ If yes, please describe including a list of all medications given at home.

_____

_____

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2. Has student had any serious injuries, illnesses, accidents or been hospitalized recently? Yes_____ No_____ If yes, please describe_____.

3. Is student required to have daily medications or medical treatments during school hours? This includes asthma inhalers, breathing treatments, injections, topical creams and oral medications. <u>These require a medication consent form</u> (attached). Please list all medications and treatments below.

1._____
2._____
3._____

please complete reverse

MEDICAL EXEMPTION FROM IMMUNIZATION

This form must be completed by a physician (MD/DO) or Tennessee Department of Health Public Health Nurse (PHN) licensed in the State of Tennessee to document a true medical contraindication/precaution to an immunization(s). This document may be accepted by agencies that require proof of medical exemption.

Tenn. Comp. Rules and Regs. 1200-14-01-.29(18)(a) provides for an exemption where a determination is made that a particular vaccine is contraindicated for one of the following reasons: 1. The individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; or 2. The individual meets the criteria for contraindication published by the U.S. Centers for Disease Control or the ACIP; 3. In the best professional judgment of the physician, based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. An individual who has been exempt from a particular vaccination **must comply with immunization requirements for any vaccine from which he/she has not been exempt**. See *Tenn. Comp. Rules and Regs. 1200-14-1-.29-(18)(b), T.C.A. Section 68-5-106(b)* states that **any physician fraudulently giving a certificate of sickness or of vaccination to prevent vaccination commits a Class C misdemeanor**.

Patient Name (*please print*): _____ DOB: ____/____/____

Parent/Guardian Name: _____ Parent/Guardian Phone: (____) ____-____

Patient/Parent Address: _____ County: _____

Child Care/School/College/University: _____

Medical contraindications and precautions for immunizations are described in the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP), available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html#t-02.

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication is present. A **precaution** is a condition in a recipient that **might** increase the risk for a serious adverse reaction or that **might** compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be **deferred** when a precaution is present and administered after the precaution resolves.

Vaccine	Check all true contraindications and precautions that apply to this patient.
☐ **Diphtheria, Tetanus, Pertussis (DTaP)** ☐ **Tetanus, Diphtheria, Pertussis (Tdap)** ☐ **Tetanus, Diphtheria (DT, Td)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizure) not attributable to another identifiable cause within 7 days of administration of DTaP or DTP (for DTaP); or of previous dose of DTaP, DTP, or Tdap (for Tdap). ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ☐ Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid-containing vaccine. ☐ History of arthus-type hypersensitivity reaction after a previous dose of a tetanus or diphtheria-toxoid-containing vaccine. Defer until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine. ☐ For pertussis-containing vaccines: progressive or unstable neurologic disorder (including infantile spasms for DTaP), uncontrolled seizures, or progressive encephalopathy. Defer until a treatment regimen has been established and the condition has stabilized. ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Measles, Mumps, Rubella (MMR)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy (e.g., ≥ 2 weeks of daily steroid therapy of ≥20 mg or 2 mg/kg body weight; or human immunodeficiency virus (HIV) infection with CD4+ T-lymphocyte count ≤ 15%). ☐ Family history of altered immunocompetence (e.g., first degree relative (biological parent or sibling) unless the immune competence of the potential vaccine recipient has been substantiated clinically or verified by a laboratory). ☐ Pregnancy. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions** ☐ Moderate or severe acute illness with or without fever. Defer vaccination until symptoms resolve. ☐ Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product). ☐ History of thrombocytopenia or thrombocytopenic purpura. ☐ Need for tuberculin skin testing or Interferon-Gamma Release Assay (IGRA) testing; postpone testing until ≥ 4 weeks after vaccination. MMR can be administered in the same day as TB skin testing or IRA testing. (Measles vaccine might suppress tuberculin reactivity temporarily). ***Date Exemption Ends:** _____ **MD/DO/PHN Initials:** _____
☐ **Varicella (Var)**	**Contraindications** ☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. ☐ Known severe immunodeficiency (e.g., congenital immunodeficiency, malignancy, chemotherapy, long-term immunosuppressive therapy (e.g., ≥ 2 weeks of daily receipt of ≥20 mg or 2 mg/kg body weight of prednisone or equivalent) or human immunodeficiency virus (HIV) infection with CD4+ T-lymphocyte count ≤15%. ☐ Pregnancy. ☐ These published contraindications are not true for this patient, but it is my best professional judgement that based upon the individual's medical condition and history, the risk of medical harm from the vaccine outweighs the potential benefit. **Precautions**

Religious Dietary Restriction

Name _____Classroom _____

Age_____

Does the child have a special nutritional or feeding need? NO YES
Does the child have a religious restriction(s) in his/ her diet? NO YES

Please follow the restriction(s) of the religion: _____

List any dietary restriction or special diet:

_____
_____
_____
_____

List all restricted food items. For each item, list a food to be substituted.

_____
_____
_____
_____
_____
_____

Parent/Guardian
Signature_____Date_____

Principal
Signature _____Date_____