DORSEY ATTENDANCE CENTER
STUDENT HEALTH FORM

STUDENT NAME_____ Date of Birth_____
Homeroom Teacher_____ Grade_____

Does the student have any allergies to medications, food, insects or environmental elements? YES/NO Please list allergies along with the reaction. _____
Does the allergy require an EpiPen? YES/NO
Does the student require an inhaler? YES/NO

Please list any health conditions.

1. _____
2. _____
3. _____

Please list any daily medications.

1. _____
2. _____
3. _____
4.

Will the student be taking medications at school? YES/NO
If the student requires medication at school an order from the prescribing physician and the Parent Authorization and Indemnity Agreement form MUST accompany the medication. The medication MUST be in the original bottle with the prescription label attached. A parent/guardian must bring medication to the nurse. Medication CANNOT be transported by the student.

Please list emergency contacts and phone numbers.

1. _____ Phone( )_____
2. _____ Phone( )_____
3. _____ Phone( )_____

Please indicate below which medication the school nurse is allowed to administer to the student during school hours.
By checking and signing below you acknowledge that the school nurse is authorized to administer the medications you have indicated on this form for minor aches, pains and fever in your absence while the student is at school. The Parent Authorization and Indemnity Agreement form must be signed and returned. The medication will be administered at the proper dose for age and weight per the manufacturer recommendations.

☐ Ibuprofen ☐ Tylenol ☐ Tums ☐ Saline Eye Drops

☐ Luden's Throat Drops ☐ Cough Drop ☐ Hydrocortisone Cream

☐ Children's Ibuprofen ☐ Children's Tylenol ☐ Antibiotic Cream

Do you have any other concerns the nurse should know about?_____
_____

Parent Signature_____ Date_____

ITAWAMBA COUNTY SCHOOL DISTRICT
PARENT AUTHORIZATION AND INDEMNITY AGREEMENT

We the undersigned parent(s) or legal guardian(s) of _____, a minor child, have requested personnel of the Itawamba County School District to administer prescription or over-the-counter medications to this minor child. This request has been made for our convenience as a substitute for parental administration of the medication. It is understood that some of the school personnel administering the medication will not be required to have medical or nursing training.

We forever release, discharge and covenant to hold harmless the Itawamba County School District, its personnel, employees and agents, and to further hold harmless the members of the Itawamba County Board of Education from any and all claims, demands, damages, expenses, losses or causes of action belonging to ourselves or the minor child as a result of or rising out of any injury, sickness, disability, loss or damages of any kind or nature resulting from the administration of the prescription or over-the-counter medication.

The undersigned agrees to repay the Itawamba County School District, its personnel, employees and agents, and to repay the Itawamba County Board of Education, any sum of money, expenses or attorney's fees that any of them may be compelled to pay as a result of any injury, sickness, disability, loss or damage to the minor child as a result of the administration of the medication. Additionally, the undersigned agrees to repay the Itawamba County School District, its personnel, employees and agents, and to repay the Itawamba County Board of Education, any sum of money, expenses or attorney's fees that any of them may be compelled to pay in the defense of any action brought or threatened to be brought as a result of any injury, sickness, disability, loss or damage to the minor child as a result of the administration of the medication.

We the undersigned understand that we have the right to have legal counsel read and advise us regarding this Authorization and Indemnity Agreement.

We the undersigned have read the foregoing Authorization and Indemnity Agreement and fully understand it.

Parent/Guardian: _____

Parent/Guardian: _____

Witness: _____