West Bend Mallard Community School District

Student Emergency/Health Information for Returning Students

School Year ___________

Student's Name _________________________________ Grade _______BD _________________

Permission for Medication administration at school:

I hereby give my consent to administer the below indicated medication to my student in the event of fever, or student headache symptoms. I understand that I will be contacted if student requires any medication for more than one consecutive day. This will not prevent the school from notifying me in the case of fever and the need for my child to go home.

Tylenol: ___ 325 mg.; ___ 500 mg. ___ 160 mg. ___ Liquid #/cc of ______

Acetaminophen (generic) ___ 325 mg.; ___ 500 mg ___160 mg. ___ Liquid #/cc of ______

Ibuprofen _____ 200 mg ___ 100 mg chewable ___ liquid #/cc of _______

Antacid Tablet ________ Cough Drop ________ (upon request of student)

I, _______________________________________ give my permission for my child

____________________________________to receive the above indicated medication in the event of the above described symptoms. (Dose: As I have indicated above or dose per bottle.)

Date: ___________________ Signature____

CURRENT HEALTH:

Does the student have: Asthma _____Yes _____ No

Medical Concerns: _____ Yes _____ No If yes, ____

Prescribed Medications to be taken at school ____

Over-the-counter/Prescribed Medications taken at home ___________________________________

State any allergies (Food, Medication, and/or Environmental) ________________________________

State any serious illnesses, injuries, or surgeries in the past year ______________________________

State any immunizations received and date/day given in the past year___________________________

Does your child have any emotional, social, or other conditions that might affect his/her school performance?

_____Yes _____ No If yes: ____

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Does your child use any assistive devices? (hearing aid, glasses, braces, etc.) ______________________

Does your child have any activity restrictions? ____

Current Health Insurance: ____ No Insurance ____ Medicaid ____ Hawk-I ____ Private/Name____________

If a medical emergency should arise, I agree to assume full financial responsibility for my child's medical care. I understand I am responsible for updating this information as needed. I grant my permission to share health and emergency information as stated with school staff on a need to know basis.

Signature of Parent/Guardian____ Date __________________