Dear Parent/Guardian:

I am gathering information about students who have health needs. Please fill out the form, "Request for Health Information," whether or not your student has medical needs that could affect learning or might require emergency care during the school day.

Chronic Health Conditions

- Please complete the reverse side of this form annually
- If your child has a life-threatening condition/allergy, please notify the school nurse and any other staff members who will be in contact with your child (including the cafeteria/bus driver/coach/extracurricular activities).
- Contact the school nurse if you need to schedule a conference to discuss details regarding the development of a health care plan for your child.
- Provide necessary changes that occur during the school year, either with contact numbers or your child's health condition.

Medication Administration

- Medications are to be administered at home whenever possible.
- All medications will be dispensed by school personnel. (Only exception: ASTHMATICS who have written permission from the physician that specifically states your child may carry their inhaler while at school. (An extra inhaler should be kept in the Health Room as a back-up.)
- Prescription medications: Physician consent portion AND Parent/Guardian consent portion of the medication administration form MUST be completed prior to dispensing medication at school. (Your doctor may fax consent form directly to the school nurse at: 920-532-4664)
- Non-Prescription Medications: Parent/Guardian portion of the consent form MUST be completed prior to dispensing any non-prescription medication at school. The physician consent portion must also be completed for over-the-counter medications that exceed the recommended packaging dose.
- All medication MUST be sent in their original prescription/non-prescription container. Loose pills in baggies will not be accepted.
- All medications MUST be dropped off in the school office. Make sure medications are clearly labeled with your child's first and last name.
- It is the parent/guardian responsibility to make sure your child has an adequate supply of medicine. For daily routine medication a one-month supply is recommended.
- Do not send expired medications. Please check all medication label expiration dates.
- High School students only may carry and 'self-medicate' with over-the-counter and prescription medications (EXCLUDES controlled substances) if Self-Administration is documented by Parent/Guardian and Physician on the Medication administration form.

If you have questions or concerns, please contact the school. I would be happy to speak with you.

Sincerely,
School Nurse
920-532-4818 ext 5016

Request for Health Information **WRIGHTSTOWN COMMUNITY SCHOOL DISTRICT**

Must be Completed annually

School _____Date_____
Student's Name_____ Date of Birth_____
Teacher_____ Grade_____
Parent/Guardian (names) _____
Home Phone_____ Mom's work_____ Mom's cell_____
Dad's work _____Dad's cell_____
Emergency Contact Person name and Phone _____
Drug Allergy(s) None Known ____ Yes (list) _____
Treating Physician_____ Office Phone_____

___ **MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS. (You may stop here if there are no known medical conditions. Please sign at the bottom and return.)**

Asthma Triggers: environmental __ seasonal __ exercise induced __ upper respiratory infection __ others _____
Inhaler at school- MD order required. (If student will carry inhaler must have self- administration documented by parent and MD on medication form.)
Inhaler location: Carried by student _____ Health Room_____

Diabetes Type I __ Type II__ Diagnosis Date: _____ Insulin by: Pump ___ Injections ____
Desire Diabetes Care Plan: yes ___ No, independent with all care _____
Notify your school nurse and principal immediately if newly diagnosed

Food Allergy
Peanuts_____ Tree Nuts_____ Milk_____ other(s)_____
**Date/Type of Last Reaction_____ Student Needs for Class/School_____

Severe Sting Allergy
** Date and Type/Description of Last Reaction _____
****Notify your school nurse and principal immediately if anaphylaxis may occur****

Epilepsy Type(s) of Seizure(s): _____
Controlled with medication____ on medication, continues to have seizures_____
Diastat needed at school _____ No medication needed at school _____
Date and Type/description of last seizure _____

Other conditions/or specify pertinent data to help us better serve your child:
_____

Does your child take routine medication(s) yes no List Meds: _____
Does your child need medication(s) at school? yes no List Meds: _____
If your child needs medication at school, a medication consent form is required to be signed by the health care provider and the parent/guardian.

***Medication cannot be given at the school until appropriate consents have been received. ***
****Wrightstown Community School District does not provide medications for students.****

As a parent you are responsible to inform the school of any significant medical condition updates during the school year. I give permission to the School Staff/School Nurse to share information regarding my child's medical condition(s) with my physician or emergency personnel and the school staff/teachers:

Date: _____ Parent/Guardian Signature_____

Please contact the school if you have any questions.