Annual Health Questionnaire and Consent for Administration of Approved Discretionary Medications 2017-2018

Student Name:_____**Date of Birth:**_____

School/Division:_____**Grade:**_____ **Age:** _____ **Weight:**_____

Home Phone: _____ **Cell Phone:** _____

Medical/Health Information:

Does your child have any allergies (food, environmental, etc.) or asthma? _____
_____

Please describe your child's allergic reaction(s). Be very detailed and specific. For example: Does he experience rash or hives? Does he experience difficulty breathing, swelling, or anaphylaxis? Is your child asthmatic or have a history of reactive airway? Is his asthma allergy-induced, exercise-induced, or both? What is your physician's recommended intervention? ***Be sure to enclose a medical order for whatever intervention is recommended (i.e., Epi-Pen, Albuterol, etc.).***

_____
_____

Please list any medications or treatments your child takes at home (dosage, time, and purpose)_____
_____

Baltimore County regulations prohibit school personnel from administering Tylenol or *any* other over-the-counter medication without written medical authorization from your physician *and* written permission from the parent.

I ____**DO** give permission to the Health Suite personnel to administer medications to my child.
I ____**DO NOT** give permission to the Health Suite personnel to administer medications to my child.

I would like the following medication(s) made available to my child: *(pleasecheck medication and dosage)*

For Headache/Fever/Burns/Earache/Muscle Aches/Pain
Acetaminophen (Tylenol) ___160/mg/5 ml liquid ___160 mg chewables ___ 325 mg tab
Ibuprofen (Advil) ___100 mg/5 ml liquid __100 mg chewable tab __200 mg tab
For Upset Stomach ___chewable Antacid (Tums) 500 mg
For Allergic Reactions ___Diphenhydramine (Benadryl) ___12.5 mg syrup ___12.5 mg chewable tab
For Coughs/Sore Throats ___Throat Lozenge
For Cuts/Scrapes ___ Antibiotic ointment
For Bites/ Itching ___ Hydrocortisone 1% cream
For Sun Protection ___sunscreen

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Physician **Printed Name of Physician** **Date**