Annual Health Questionnaire and Consent for Administration of Non-Prescription Medications 2018-2019

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the four sections must be completed for student to receive any over-the-counter (OTC) medication below and must be signed by a physician, dentist, or prescribing health care provider. **Circle yes or no to indicate which of the approved list of over-the-counter medications may be administered when indicated by student's symptoms.**

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Weight	Division	Grade

Parent/Guardian	Address

Home Phone	Work Phone	Cell Phone

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)

II. ACTION PLAN (To Be Completed By Parent/Guardian). Please complete all spaces. All medications will be administered according to the dosage and time listed on the manufacturer's label.

Over-the-Counter Medication	Circle	Condition/Symptoms	Possible Side-Effects	Comments
Acetaminophen (Tylenol ®)	Yes or No	For relief of minor aches & pain or fever (100 F)	None significant if administered per manufacturers label	**Alert:** Students with temperature over 100 F must be sent home
Calcium Carbonate (Tums ®)	Yes or No	For stomach ache or heart burn	Constipation	Not to be used in children less than 6 years old
Diphenhydramine (Benadryl ®)	Yes or No	For allergy symptoms	Drowsiness or excitability	
Ibuprofen (Advil ®, Motrin ®)	Yes or No	For relief of body aches & pain or or fever	Stomach upset	**Alert:** Contains no aspirin (salicylates), but should not be given if student has allergy to aspirin; may cause stomach bleeding
Hyrocortizone 1% anti-itch cream	Yes or No	For temporary relief of pain and itching caused by insect bites and stings	None significant if administered per manufacturers label	Do not use on broken skin, near eyes or mucous membranes.
Throat Lozenges (Halls)	Yes or No	For temporary relief of cough due to cold or occasional minor irritation or sore throat.	None significant if administered per manufacturers label	**Alert:** Contains soy.

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I request the school nurse or certified medication technician assist my child in the administration of the above described medication/s. I give permission for my child to take the medication indicated above by my checking the yes box according to the condition/symptoms described while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school, its personnel, or agents for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) these medications are stocked and maintained by school in generic form only; (3) I will be notified of the medication and time that the OTC medication was administered to my child only if requested below; (4) I will be contacted if my child's symptoms do not improve and s/he is unable to remain at school. ____ I request to be notified if over the counter medications are administered to my child at (_____)______-________

Parent/Guardian Signature:____ Date:____________________

Students are not permitted to have any over-the-counter medications at school or school sponsored activities.

☐ **Please check this box if you do NOT want your child to receive any of the medications listed above.**

IV. PHYSICIAN CONSENT (To Be Completed by the Prescribing Physician, Dentist, or Licensed Prescriber.) Form is void if this section is incomplete.

I request that the school nurse or a certified medication technician administer any of the above listed medications to the student listed above in accordance with the conditions listed on this form as well as the manufacturer's label. I understand that by signing this I am the prescribing party for these orders for the student listed on this form.

Prescriber Name:____________________________________ Prescriber Signature:______________________________

Date:___________________________ Phone Number:__________________________________

ישיבת חפץ חיים
TALMUDICAL ACADEMY
OVER ONE HUNDRED YEARS OF BUILDING TORAH

MEDICATION PROTOCOL AT SCHOOL
PARENT RESPONSIBILITIES

Prescription Medication

1. An Authorization for Administration of Prescription Medication form must be filled out by the physician, and signed by the parent.
2. A separate authorization form must be filled out for **EACH** medication administered.
3. Changes in medication require a **new** authorization form signed by the physician and parent.
4. Medication must be in the original pharmacy-labeled container.
5. No more than a 30-day supply of medication may be accepted.
6. A responsible adult must deliver and pick-up the medications in the school.
7. Notify school staff directly of any medication changes, including discontinued medications.
8. Discontinued medication must be picked up by parent within one week of the stop date. Unclaimed medication will be destroyed one week after the stop date.
9. During the last month of the current school year, bring only enough medication to be used by the last day of school. Unclaimed medication will be destroyed at the close of the last day of school.

Non-Prescription Medication

1. The **ONLY** non-prescription medications/over-the-counter medications that will be administered at school are:
   - a. Acetaminophen (Tylenol®)
   - b. Calcium Carbonate (Tums®)
   - c. Diphenhydramine (Benadryl®)
   - d. Ibuprofen (Advil®, Motrin®)
   - e. Hydrocortizone 1% Topical Cream
   - f. Throat Lozenges (Halls)

   If your child requires any non-prescription medications that are not listed above, an Authorization of Prescription Medication form signed by the student's physician and parent is required.

2. The Annual Health Questionnaire form is available in the school for parent to indicate which of these OTC medication/s can, or cannot, be administered to the student each school year.
3. Over-the-counter medications as listed above are provided and maintained by the school health staff in the school in the original containers with the manufacturer's label.
4. Notify school staff directly of any medication changes, including withdrawal of parental consent.
5. If parents wish to have brand name medication (Such as Tylenol, Benadryl, Advil, etc) administered to their child it must be sent in to school in a closed container with your child’s name on it.