Bradford Public School District Mandatory Health and Release Form

Student: ______________________________**DOB** _____________**Grade**_______

Address:____

Mother:________________________________**Phone:**________________________

Father: ________________________________**Phone:** _______________________

EMERGENCY CONTACTS: (parents will be contacted first, 3 Reliable people)

1. ________________________________**Phone:** _______________________
2. ________________________________**Phone:** _______________________
3. ________________________________**Phone:** _______________________

Private Insurance:______________________ **Policy#:** ______________________

Group#: _______________________________**Phone#:**_______________________

AR Kids/Medicaid # ____

Does your child have any allergies? YES or NO (circle one) if "Yes", please list____

My child has permission to be given these NON-PRESCRIPTION medications. I understand that the school nurse (or trained staff) will determine if the medication is needed, and will administer the age/weight appropriate dose. Generic forms of the medication may be used. I understand that unexpected adverse reactions may occur from any medication, and hereby release Bradford Public School District and its employees from any liability to such unexpected reactions.

****Acetaminophen (Tylenol)- age and weight appropriate**
****Ibuprofen (Motrin)- age and weight appropriate**
****Antacid (Tums/Maalox)**
****Cough Drops**
****Topical Ointment (antibiotic ointment, burn ointment, anti-itch cream, etc.)**

*******As a general rule these medications are not given before 10:00 a.m. or after 2:00 p.m. to reduce the possibility of over-medicating any student.**
****Benadryl is given Only in cases of acute allergic reaction.**

I DO NOT want my child to have OTC medication at school. (Please circle) NO

Parent/Guardian's Signature: _______________________________ **Date**___________

Health History

Student Name:____

Please check "Yes" or "No" on all health concerns. If you answer "yes", please answer the questions associated with that health concern.

**(Please ask your doctor to provide written orders for management of this medical condition at school.)*

Yes	No	Health Concern	Description
		ADD/ADHD*	Medication required?______ Name of medication:______ Given at school? Doctor's name/Phone:
		ASTHMA* (Diagnosed by a doctor)	Medication/inhaler? ______ Daily? ______ As needed? ______ With exercise? ______ Name of medication:______ In nurse's office? ___________ Student carries/administers inhaler? ______ How often seen by doctor? Last ER visit due to asthma?
		ALLERGIC REACTION	To what? ______ Hives/Rash? Yes___ No___ Breathing difficulty? Yes___ No___ Other? ______ Has EpiPen? Yes___ No___ Where is EpiPen kept? Nurse's Office ___ Carries own ___ Doctor's Name/Phone:
		BONE/JOINT PROBLEMS	Any physical limitations? ______ History of broken bones? ______ Osgood–Schlatter disease? Arthritis? Other?
		DEPRESSION	Medication required? Yes___ No___ Given at school? Yes___ No___ Name of medication:
		DIABETES*	Type I____Type II____ Medications? Oral_____ Injection_____ Pump_____ Doctor's Name/Phone:
		EAR PROBLEMS	Frequent infections? Past___ Present___ Tubes? Past____ Present____ Permanent hearing loss? Hearing Aid?
		HEART PROBLEMS*	Diagnosis: ______ Physical restrictions? Yes___ No___ Medications? Yes___ No___ At Home? ____ At school? _____ Name of medication:
		HYPERTENSION	Medication required? Yes___ No___ What time is medication given? ______ Name of medication:
		FREQUENT HEADACHES MIGRAINE HEADACHES*	Frequency?______ Known Triggers:______ Best Treatment?
		SEIZURE DISORDER*	Frequency of seizures? ______ Date of last seizure? ______ Name of medication:
		VISION	Wears glasses? _____ Contacts? _____ Reading only? _____ All the time? _____ Date of last exam? ______ Doctor's Name/Phone:
		OTHER HEALTH CONCERNS?* (Cystic Fibrosis, Celiac Disease, Hemophilia, etc.)	Diagnosis:______ Medications: ______ Doctor's name/phone: