**Westbrook Middle/High School**

**Annual Student Health Update and Standing Order Parent Authorization Form**

*This form must be completed and forwarded to the health office yearly.*

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_

**Annual Standing Order Parent Authorization**

The registered nurse covering the Westbrook Public Schools may administer the following medication to students at the discretion of the nurse provided that prior permission has been signed by the parent/guardian for the school year. Please sign for each medication that you authorize the nurse to administer. If you do not want medication given to your child, please leave blank.

I authorize the nurse, with a standing order from the school medical advisor, to administer at his/her discretion the following medications to my child (Please sign for each medication as appropriate):

* **Acetaminophen (Tylenol)** 325 mg each 1-2 tabs every 4-6 hours as needed for headaches or minor pain. **Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Ibuprofen (Advil)** 200 mg each 1-2 tabs every 4-6 hours as needed for muscle pain, menstrual cramps, and headaches.  **Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Cetirizine HCl (Zyrtec)** 10 mg each 1 tablet once a day for seasonal allergy symptoms such as sneezing, itchy eyes, or runny nose. **Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NOTE:  If any other medication is to be given in school,including any over the counter medication, it must be accompanied by a signed AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM.

**Annual Confidential Health Update**

**1. My Child Has The Following Medical Condition(s):**

Allergies: Life Threatening/Non-Life Threatening (please circle)

Bee Sting\_\_\_\_\_ Food\_\_\_\_\_ Medication\_\_\_\_\_ Latex\_\_\_\_\_ Other(please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma\_\_\_\_\_ Diabetes\_\_\_\_\_ Seizures\_\_\_\_\_ Cancer\_\_\_\_\_ ADHD\_\_\_\_\_ Behavioral/Emotional\_\_\_\_\_

Conditions: Cardiac\_\_\_\_\_ Orthopedic\_\_\_\_\_ Urinary\_\_\_\_\_ Psychological\_\_\_\_\_ Neurological\_\_\_\_\_\_ Respiratory\_\_\_\_\_ Gastrointestinal\_\_\_\_\_ Renal\_\_\_\_\_ Hormonal\_\_\_\_\_ Autoimmune\_\_\_\_\_

Problems with: Vision\_\_\_\_\_ Hearing\_\_\_\_\_ Swallowing\_\_\_\_\_ Speech\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF ANY LIFE THREATENING ALLERGIES, ASTHMA, OR SEIZURES ARE CHECKED, PLEASE HAVE THE PHYSICIAN COMPLETE A TREATMENT PLAN AND SEND MEDICATION ORDERS.**

**2. Please list any medication your child takes regularly and reason for medication:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**3. Any serious accident(s), operation(s), or illness(es) in the last year?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Does your child have health insurance? Yes/No (please circle)**

Name of Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Is there anything you would like to discuss with the school nurse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 1/8/2020