St. Joseph School Yearly Health Update

Year______

Child's Name________________________________ Grade/Teacher ____________________

Please take time to fill out the questionnaire below thoroughly so we may care for your child properly. For the following questions, please answer yes or no.

1. Do you have any concerns about your child's general health (eating, sleeping, weight, etc.)?
2. Does your child have any specific illness or problem?
3. Does your child have any allergies (food, insects, medications, etc.)?**
4. Does your child take any medications (daily or occasionally)?
5. Does your child have any problem with vision, hearing or speech (glasses, contacts, etc.)?
6. Has your child had any hospitalization, operation or major illness? Specify below.
7. Has your child had any significant injury or accident? Specify below.
8. Would you like to discuss anything about your child's health with the school nurse?

Please explain any "yes" answers below. For illness/injury include year/child's age at the time:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

** If your child will be taking medication at school, an authorization form must be filled out by the physician.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school. I give St. Joseph School permission to treat and/or transport my child in the event of an emergency.

__________________________________________ ____________________

Signature of parent/guardian Date

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PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF ACETAMINOPHEN

Under the standing orders of our medical advisor, Acetaminophen (Tylenol) may be given to students with parent/guardian written permission for headaches, earaches, menstrual cramps and toothaches. If you wish to allow your child to receive Acetaminophn for these ailments at school please complete the following:

I give my permission for my child to receive Acetaminophen (Tylenol) at St. Joseph School per manufacturer's dosing:

Circle: Yes No

________________________________________ __________________

Signature of parent/guardian Date

| Date | Time | Dose | Comments | Signature |
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Authorization for the Administration of .Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be In the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student________________________

Date of Birth_/__/________Today's Date_/___/_____

_Address of Child/Student__________________________________
Town_________________________________________________
Medication Name/Generic Name of Drug:
______Controlled Drug? YES/NO

Condition for which drug is being administered:

Specific Instructions for Medication Administration
Dosage_________Method/Route_________________
Time of Administration____________If PRN, frequency___________
StartDate_____/____/________
End Date _____/____/________
Medication shall be administered: Start Date:__/__/__End Date: __/__/______
Relevant Side Effects of Medication-_______________________________________
Explain any allergies, reactions to/negative interaction with food or drugs
______________________________________________________________________
______________________________________________________________________

Plan of Management for Side Effects-

Prescriber's Name:

Phone Number
Prescriber's Address:
Prescriber's Signature___________________________________Date:___________
School Nurse Signature (if applicable):_____________________________________
Parent Guardian Authorization:

I request that medication be administered to my child/student as described and directed above. I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse to ensure the safe administration of this medication. I understand that I must supply the school with no more than three months' supply of medication. I have administered at least one dose of the medication to my child without adverse effects.

Parent/Guardian Signature______________________Relationship_________________

Parent/Guardian's Address______________________________________________________

Town_________________________State_____

Home Phone# Work Phone# Cell Phone#

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: YES/NO

_____________________________________________ ___________________

Signature of prescriber______________________________ Date__________

Parent/Guardian authorization for self-administration: YES/NO

Signature __________________________________

Date _____________

School nurse,if applicable, approval for self-administration:
__________________________________________ YES/NO

Today's Date___________________

PrintedNameofIndividualReceivingWrittenAuthorizationandMedication--------

Title/Position/Signature (in ink) _______________________________________

Note:ThisformisasampleformincompliancewithSection10-212a,Section19a-79-9a,19a-87b-17a
nd19-13-B27a(v.)