Arlington School – 115 Mill Street, MS 111, Belmont, MA 02478 – (617) 855-2124

Health Office Information Card

SY_____/_____

Student Name _____ DOB _____ Grade ____

Current Address _____

_____ Zip _____

Lives with: ☐ Parent #1 ☐ Parent #2 ☐ Both ☐ Other: _____

If a medical emergency arises, we want to respond according to your wishes. Please provide the following information and **indicate the order** in which people should be contacted by placing the number next to the contact.

☐ **Parent #1** _____

Home Ph _____ Cell Ph _____

☐ **Parent #2** _____

Home Ph _____ Cell Ph _____

Please list two (2) contacts whom we may call or to whom we may release your child in an emergency.

☐ **Contact** _____ Relationship _____

Home Ph _____ Cell Ph _____

☐ **Contact** _____ Relationship _____

Home Ph _____ Cell Ph _____

Pediatrician _____

Office# _____ Ext _____ Fax# _____

Psychiatrist _____

Office# _____ Ext _____ Fax# _____

Dentist _____

Office# _____ Ext _____ Fax# _____

Please record any allergies to the following:

Allergy to:	Record Allergy:	Describe Reaction:	Describe Treatment:
Medication:			
Food:			
Other:			

_____ _____

Signature of Parent/Guardian **Date**

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Student Health Screening Form

Student Name _____ **DOB** _____

In combination with the most recent record of your child's **Physical Exam, Immunization Records** and **Dental Exam,** please complete the following checklist and supply all documentation to Arlington School's Nurses Office upon enrollment or at the beginning of each school year.

Y	N	
☐	☐	Has your child had a Physical Exam in the past year? Doctor's Name _____ Exam Date _____
☐	☐	Has your child had a Dental Exam in the past year? Dentist's Name _____ Exam Date _____
☐	☐	Does your child see an Orthodontist?
☐	☐	Has your child ever had an allergic reaction? Explain: _____
☐	☐	Has your child ever had an allergic reaction to medication?: Explain: _____
☐	☐	Does your child have a chronic or ongoing illness?: Explain: _____
☐	☐	Has your child ever had surgery?: Explain: _____
☐	☐	Does your child have any physical limitations that may require program modifications and/ /or restrictions? Explain: _____
☐	☐	Has your child ever taken any supplements or vitamins to help gain or lose weight to improve performance?: Explain: _____
☐	☐	Has your child ever experienced a seizure or convulsions?: Explain:
☐	☐	Has your child ever had a head injury or concussion: Explain: _____
☐	☐	Has your child ever been knocked out, lost consciousness, or lost his/her memory?: Explain: _____

Please check all medical conditions that apply:

GENERAL
- ☐ Recent weight loss or gain
- ☐ Heat or cold intolerance
- ☐ Difficulty sleeping

HEAD, EYES, EARS, NOSE, MOUTH, THROAT
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of hair
- ☐ Hearing difficulties
- ☐ Dry mouth
- ☐ Vision, glasses, contacts

RESPIRATORY
- ☐ Asthma
- ☐ Use inhaler

CARDOVASCULAR
- ☐ Irregular heart beat
- ☐ Murmur
- ☐ Palpitations
- ☐ Under a doctor's care

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Heartburn, indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain or cramps in abdomen
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting blood

SKIN
- ☐ Hives or welts
- ☐ Easy bruising

INFECTIOUS – RECURRENT INFECTIONS
- ☐ Ear
- ☐ Sinus
- ☐ Lung
- ☐ Skin
- ☐ Bone
- ☐ Other: _____

GEMOTPIROMARY
- ☐ Pain with urination
- ☐ Increase in frequency/urgency with urination
- ☐ Blood in urine

FEMALES ONLY
- ☐ Menstrual cycles, started at age: _____
- ☐ Regular cycle
- ☐ Pregnant

MALES ONLY
- ☐ Rash or sores on penis
- ☐ Discharge from penis

BONES, MUSCLES, JOINTS
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Numbness or tingling

NERVOUS SYSTEM
- ☐ Seizures
- ☐ Under a doctor's care
- ☐ On medication

Signature of Parent/Guardian **Date**

Signature of Student if 18 years of age or older **Date**

Should your child have a health condition that is not included on the above list or a condition that has developed throughout the school year, please contact the School Nurse at (617) 855-2124 so we may update our medical information records.

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Over –the-Counter Medication Administration and Consent Form

Student Name _____ **DOB** _____

Height _____ Weight _____ Gender _____ Grade _____

Primary Address _____

_____ Zip _____

Parent #1	_____	Parent #2	_____
Home	_____	Home	_____
Cell	_____	Cell	_____

Person to be notified in an emergency, in case parent/guardian cannot be reached:

Emergency Contact _____
Phone Number _____
Relationship _____

Please list **all** over-the-counter **medication/vitamins** your child receives including those given during the school day (**Tylenol, Ibuprofen, Advil, Multi-Vitamin, Tums, etc**.).

1. _____	2. _____	3. _____
Dose: _____	*Dose:* _____	*Dose:* _____
4. _____	5. _____	6. _____
Dose: _____	*Dose:* _____	*Dose:* _____

Protocol to administer Tylenol or Ibuprofen to students during school hours:

Tylenol (650 mg)	650mg may be administered to a student every four hours for headache or menstrual cramps with written parent/guardian authorization and documentation on Medication Log for each student.
Indications	for treatment of menstrual cramps or headache not associated with other conditions
Contraindications	sensitivity to acetaminophen or aspirin
Potential Adverse Effects	Incidents of adverse effects is very rare with Tylenol. They include agranulocytosis (fever, sore throat, white sore spots on the lips or in the mouth), anemia allergic dermatitis, and renal failure.

Ibuprofen (400mg to 600mg)	400mg to 600mg may be administered to a student every six hours for headache or menstrual cramps with written parent/guardian authorization and documentation on Medical Log for each student.
Indications	for treatment of menstrual cramps or headache not associated with other conditions
Potential Adverse Effects	gastrointestinal irritation (can be helped by taking with food), increased toxic effects if combined with Lithium.

CONSENT

I give permission to the Arlington School Nurse, or an authorized school staff member, to give the following medicine(s) to my child: TUMS

- ☐ **Tylenol (650mg) every 4 hrs**
- ☐ **Ibuprofen (400mg/600mg) every 6 hrs**

I give permission to the school nurse to share with appropriate school personnel information relating to the administration of the above consented over-the-counter medications in relation to my child's health and safety. ☐ YES ☐ NO

Signature of Parent/Guardian **Date**

-and-

Student's Signature if 18 years of age or older **Date**

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Prescription Medication Administration Plan and Consent Form

Student Name _____ **DOB** _____

Primary Address _____

_____ Zip _____

Parental Contact _____ **Emer Contact** _____

Home _____ Home _____

Cell _____ Cell _____

Work _____ Work _____

In conjunction with the ***Prescription Medication Order Form, #M4.01***, please list, within your statement of consent, the prescription medication and its' dosage your child will receive during the school day.

CONSENT

I give permission to the school nurse, or an authorized school staff member, to give the following ***prescription medicine***, _____ ***dose*** _____ which has been ***prescribed by***, _____ to ***my child***, _____ . ☐ YES ☐ NO

I give permission for my child to self administer the above mentioned medication if the school nurse determines it is safe and appropriate: ☐ YES ☐ NO

I give permission to the school nurse to share with appropriate school personnel information relating to the administration of the above mentioned prescription medications in relation to my child's health and safety. ☐ YES ☐ NO

I give permission to the school nurse, or an authorized school staff member, to give the above mentioned medication while on school authorized field trips: ☐ YES ☐ NO

I understand that I may retrieve the above mentioned prescription medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

_____ _____

Signature of Parent/Guardian **Date**

Medication Administration Plan

For Office Use Only

Student Name _____ DOB _____
Height _____ Weight _____ Gender _____ Grade _____

Licensed Prescriber: _____
Business Number: _____ Fax Number: _____

Name of Medication _____

Qty of Medication Received: _____ Date: _____

Date Ordered: _____ Expiration Date: _____

Duration of Order: _____ Dosage: _____ Frequency: _____

Route of Administration: _____

Specific Directions: *(times to be given)*

AM: _____ PM: _____ As Needed: ☐

Required Storage Conditions: _____

Possible Side Effects: _____

_____

Administration Location: _____

Plan for Monitoring: _____

_____

Delegated to: _____

Back-up Plans *(if delegate is unavailable)* : _____

Plan for Field Trips: _____

Plans for teaching self administration, if applicable: _____

_____

Other persons to be notified of medication administration: _____

Other medications being taken by the student : _____

School Nurse Signature_____ **Date:**_____

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Prescription Medication Order Form for Doctor or N.P. or P.A.

Student Name _____ DOB _____
Height _____ Weight _____ Gender _____ Grade _____
Primary Address _____
_____ Zip _____

Name of Licensed Prescriber _____
Title _____
Business Name _____
Main No _____ Fax No _____

Please note: ***Use one prescription per order form***
Whenever possible, medication should be scheduled at times other than school hours.

Medication _____ Dosage _____
Route of Administration _____ Frequency _____
Time(s) of Administration _____

Specify directions and/or information for administration _____
_____

Date of Order _____ Date Discontinued _____

Special side effects, contraindications, or possible adverse reactions of which to be observed _____

Date of next scheduled visit to the licensed prescriber _____

If not in violation of confidentiality policy, please supply the following:

Diagnosis: _____

List other medical conditions:

_____

_____ _____
Signature of Licensed Prescriber **Date**

_____
Print Name

FORM M5
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