TAPA
Artists. Scholars. Stars.

*Health Office - **CONFIDENTIAL***
STUDENT HEALTH HISTORY
2020-2021

Student's Name_____**Date of Birth**_____ **Grade**_____

1. **Please check if your child has any of the following and explain below:**

_____ Allergies
_____ Asthma or respiratory disorders
_____ Attention difficulties
_____ Diabetes Type 1 ___ Type 2 ___
_____ Lyme disease
_____Mononucleosis
_____ Strep throat
_____ MRSA infection
_____ Headaches/Migraines
_____ Seizures
_____ Anxiety
_____ Depression
_____Substance abuse
_____ Anger issues
_____ Eating disorder
_____ Other mental health issues
_____ Gastrointestinal issues/conditions
_____ Ulcers
_____ Weight problems
_____ Menstrual problems
_____ Heart disease
_____ High blood pressure
_____ Urinary Tract Infections
_____ Kidney problems
_____ Musculoskeletal
_____ Pain
_____ Wears eyeglasses or contacts
_____ Uses a hearing aid or has hearing difficulties

Explain any checked answers:
_____

_____

2. **Please note <u>any</u> health problems, long-term health conditions or learning differences that may affect behavior or health at school:**

_____

_____

3. **Has student been hospitalized or received any treatment for injures in the last year?**

☐ Yes ☐ No If yes, please note the date and reason for hospitalization or treatment:

_____

_____

4. **Please note any psychological/emotional health issue(s) that may affect behavior or health at school:**

_____

_____

5. **Release of Information**

The School Nurse has permission to release the above health information on a need-to-know basis to school personnel (such as Principal, Teacher, School Counselor or Guidance Counselor).

☐ Yes ☐ No

Doctor's name _____
Phone Number _____

Parent/Guardian Signature _____
Date _____

TAPA

Health Office - CONFIDENTIAL

OVER THE COUNTER MEDICATION PERMISSION

2020-2021

Student's Name_____ **Date of Birth**_____ **Grade**_____

(Last Name) (First Name)

TAPA will administer over-the counter medications approved by a child's parent/guardian under the discretion of the school nurse in consultation with the school doctor. A limited supply of more commonly prescribed medicines (Tylenol, Motrin, Robitussin DM, and Benadryl) will be available in the school nurse teacher's office for the treatment of unanticipated ailments during the school day. Other over-the-counter medicines may be provided by a student's parent/guardian on an as needed basis. Students are not allowed to carry any medication(s) at school except for inhalers or Epinephrine auto-injectors.

The following over-the-counter medications or their generic equivalent may be given to my child under the discretion of the school nurse teacher. Dosing should follow the manufacturer's guidelines unless specified below.

For fever/minor pain: headache, menstrual cramps, musculoskeletal pain ☐ Yes ☐ No Acetaminophen (Tylenol) ☐ Yes ☐ No Ibuprofen (Motrin, Advil)	**For minor cough:** ☐ Yes ☐ No Robitussin DM ☐ Yes ☐ No Cough Drops
For minor abdominal pain: ☐ Yes ☐ No Tums ☐ Yes ☐ No Maalox	**Topical Products:** ☐ Yes ☐ No Anti-itch gel ☐ Yes ☐ No Triple antibiotic ointment
For minor allergic reactions/rash with itching: ☐ Yes ☐ No Benadryl	

1. **Medication History**

   ☐ **NO** Medications taken daily ☐ Medications taken daily (prescription and non-prescription).
   Please note drug name, dose and time taken.

   _____

   _____

   _____

2. **Allergy History**
   Please note all drug, food and/or environmental allergies and reaction(s) if known:

   _____

   _____

   _____

3. **Does the student carry an Epinephrine auto-injector (i.e. EpiPen)?** ☐ Yes ☐ No
4. **Does the student carry an inhaler?** ☐ Yes ☐ No

Parent/Guardian Signature _____ **Date** _____

Health Office - *CONFIDENTIAL*
MEDICATION AUTHORIZATION
2020-2021

Student's Name_____ **Date of Birth**_____ **Grade**_____
(Last Name) (First Name)

This form must be submitted for any medication (including over the counter) to be administered at school. It must be signed by an authorized provider and a parent. Students can not carry any medication while at school. All medication must be kept in the School Nurse's office except for the specific medications listed below.

To be completed by physician or authorized prescriber:

Special Instructions for ***inhaled medications***:

☐ This student is capable and responsible to self carry and self administer prescribed inhaler noted below.

Special Instructions for ***Epinephrine auto-injector***:

☐ This student is capable and responsible to self carry and self administer prescribed Epinephrine auto-injector noted below.

Medication: _____

Dose: _____ Route: _____Approximate Time of Administration: _____

Duration of order: From: _____ To: _____

Diagnosis/Reason for medication: _____

Restrictions, side effects or other instructions:_____

Medication: _____

Dose: _____ Route: _____Approximate Time of Administration: _____

Duration of order: From: _____ To: _____

Diagnosis/Reason for medication: _____

Restrictions, side effects or other instructions:_____

Physician/Authorized Provider's Signature:_____ **Date**_____
Address: _____
Phone:_____

To be completed by parent/guardian:
I request that my child be given the above medication at school or be permitted to self-carry/self-administer as authorized by the prescriber, myself and according to school policy. Medication must be supplied to the Health Office by in the original prescription container labeled with the student's name, name of the medication, dose and frequency. I understand that if it is necessary for my child to take medication on a field trip away from school, I will provide one school day's supply of the medication in the original prescription bottle for my child to self-carry and self-administer.

Parent/Guardian Signature_____ **Date**_____