Student Name: ____ Grade: ________ Teacher: _________________________

Medications taken at home/school: ____

Health Conditions, which may affect school activities: ____

Medical Alert: ____

Health Care Provider: ___________________________ Address: _____________________________ Phone: ________________

Dentist: ______________________________________ Address: _____________________________ Phone: ________________

Health Specialist: ______________________________ Address: _____________________________ Phone: ________________

Disclosure of Information

By signing this section, I am giving the school nurse or principal my permission to disclose health information pertinent to the health and safety of my child to staff who need to know. This is done with the understanding this information is to be considered and treated as confidential by those who receive it.

Parent/Guardian Signature: ____ Date: ________________

EMERGENCY TREATMENT AUTHORIZATION

On rare occasions an emergency arises and we are unable to contact a parent/guardian, or emergency contact. In order that no delay may occur that might jeopardize the life of a student, the school requests permission from the parent/guardian to seek emergency treatment.

I hereby grant permission to the SAU #39 School District to administer First Aid, secure proper medical treatment, and/or hospitalize my Son/Daughter/Ward: (student's name): ____

In case of emergency, provided they are unable to communicate with me, and according to their best judgment, further delay may jeopardize the life or health of my (son/daughter/ward).

INSTRUCTIONS OR COMMENTS: ____

Date: _____________________________ **Parent/Guardian Signature**: ____

OVER THE COUNTER MEDICATION AUTHORIZATION AUTHORIZATIONS

The N.H. Board of Nursing requires parent's written authorization for the school nurse to dispense any over-the-counter medication. The following over-the-counter medications are available in the Health Office. If you want your child to receive any of these medications (per package directions), please sign off on EACH medication. If you do not sign, we cannot dispense it.

I herby grant the SAU #39 staff to administer/assist my child (student name) ______________________________________
In taking the following medications/topical treatments <u>per package directions for weight/age.</u> I understand the pain medications will only be administered under circumstances for significant discomfort (headache, menstrual cramps, musculoskeletal pain) or fever. They would <u>not</u> be administered for stomachache, pain from head injury, or in the event of potential internal injury. I certify, to the best of my knowledge, my child has no allergy or sensitivity to and of the medications I am permitting the school nurse to dispense. Should my child develop any allergy or sensitivity, I will notify the school immediately. I agree to hold harmless the SAU #39 school districts from any liability or responsibility for and harmful effects that may occur as a result of my child taking the medications I have permitted.

<u>Acetaminophen</u> (generic Tylenol) for pain/fever: (parent/guardian signature): ____

<u>Bacitracin</u> (antibiotic ointment) for wound care: (parent/guardian signature): ____

<u>Calamine Lotion</u> for insect bites/itchy rashes: (parent/guardian signature): ____

<u>Diphenhydramine</u> (generic Benadryl): (parent/guardian signature): ____
for allergy symptoms: *(there is a dose range Diphenhydramine – <u>minimum dose</u> will be given first unless otherwise specified)*

<u>Hydrogen Peroxide</u> for wound care: (parent/guardian signature): ____

<u>Ibuprofen</u> (generic Motrin) for pain/fever: (parent/guardian signature): ____

AMHERST ELEMENTARY SCHOOLS

Name: ____ Birth Date: _________________

School: ____ Grade: _____________________

PHYSICAL EXAMINATION

N for Normal – otherwise specify

Height _____ Weight _____ Hemoglobin _____ Glands _____

Eyes _____ Vision _____ Heart _____

Ears _____ Hearing _____ Orthopedic _____ Lungs _____

Nose _____ Nutrition _____ Lordosis _____ Hernia _____

Tonsils _____ Speech _____ Scoliosis _____ Skin _____

Teeth: Temporary _______________ Nervous System

Permanent _______________ (specify if epilepsy) ____________________

Last Dental Appointment: _______________________

Recommendations and/or special instructions: ____

____

Previous diseases & operations: ____

____

Is this child capable of carrying a full program of schoolwork including gymnastics and athletics?

Yes _____ No _____

Please list any allergies: ____

IMMUNIZATIONS AND TESTS

(Specify if child has had a disease. Please attach any exemptions)

Please enter month/day/year as required by NH State Law for the following:

	1st	2nd	3rd	4th	5th
DPT/TD					
TOPV					
HepB					

MMR _______ 2nd Measles _______

Varicella _______

HIB _______ _______

_______ _______

DATE OF EXAMINATION: ____________________________________

EXAMINING PHYSICIAN: ____________________________________