2019-2020 KUEMPER ANNUAL STUDENT HEALTH UPDATE

Please complete, sign, and return to the school office or school nurse with registration materials.

Student _____ Grade _____ Parents Name _____

Does your child have any of the following?

ADD/ADHD	❒ No	❒ Yes	Epilepsy (seizures)	❒ No	❒ Yes	Kidney Problems	❒ No	❒ Yes
Asthma	❒ No	❒ Yes	Eczema/Skin Condition	❒ No	❒ Yes	Scoliosis	❒ No	❒ Yes
Diabetes	❒ No	❒ Yes	Frequent Nosebleeds	❒ No	❒ Yes	Seasonal Allergies	❒ No	❒ Yes
Dizziness/Fainting	❒ No	❒ Yes	Headaches / Migraines	❒ No	❒ Yes	Stomach Concerns	❒ No	❒ Yes
Ear Infections	❒ No	❒ Yes	Heart Conditions	❒ No	❒ Yes	Other	❒ No	❒ Yes
Hepatitis	❒ No	❒ Yes	Bowel/Bladder Concerns	❒ No	❒ Yes			

If you answered yes to any of the above, please provide more information about current problems/management. See below for medications used.

_____

_____

_____

Please list any medication (name, dosage, time) your child will be taking:

At School _____ **At home** _____

_____ _____

_____ _____

(You will be required to complete a medication permission form for your child to take any medication at school. This will be completed for all new medications and each time there is a change in dosage, time or administration. Medication must be sent to school in the original container with the child's name on the container. A doctor's note will be required when a change in any long term medication is made.)

*****Over the counter medications:** I give my permission to for my child to use triple antibiotic ointment (generic Neosporin), cough drops, calamine lotion, tums, and caladryl (anti-itch lotion) as needed during school hours. ❒ No ❒ Yes

Allergies to medications? ❒ No ❒ Yes (please list) _____

Allergies to foods? ❒ No ❒ Yes (please list) _____

Allergies to latex? ❒ No ❒ Yes (please list) _____

Does your child require use of an EPI-PEN? ❒ No ❒ Yes → *Any life threatening allergies (food, bee sting, etc.) requires a written note from your doctor with specific instructions for school.*

❖ Has your child received any immunizations in the *past year*? ❒ No ❒ Yes
If answered yes, please list date_____ Vaccination name _____

❖ Has your child had any recent injury/illness that might limit him/her in school? ❒ No ❒ Yes
If yes (describe) _____

_____

Has your child had any surgeries this past year? ❒ No ❒ Yes

If yes, please list _____

❖ Has your child ever had ear tubes? ❒ No ❒ Yes → Are they still in place? ❒ No ❒ Yes
Known hearing problem? ❒ No ❒ Yes → Wears a hearing aid? ❒ No ❒ Yes

❖ Eyes and vision-check any that apply:
_____Wears glasses → ❒ to be worn at all times ❒ to be worn for reading only ❒ to be worn for distance only
_____ Wears contacts
Month/year of last vision exam by eye specialist _____

❖ Additional information you wish to share _____

_____

Signature of Parent/Guardian _____ **Date** _____

Information that is vital to the safety of your student will be shared with the appropriate staff.

Middle School and High School Students Only

Tylenol (Acetaminophen) or Advil/Motrin (Ibuprofen)

Medication Permission Form

2019-2020

The Kuemper School Board assumes no responsibility for medical treatment of students. No medication will be administered without written authorization from the parent / guardian.

This medication permission form is specifically for over-the-counter Tylenol (Acetaminophen) or Advil (Ibuprofen) for students in **grades 6-12** who have **occasional** headaches, cramps, minor muscle aches, pain from braces, etc. The school will provide these medications at no cost to the student. If the student use becomes frequent, but needed, the parents will be notified and asked to supply medication for that student.

When a student requests these medications, he/she will be asked a few questions regarding their complaint. If the medication is deemed necessary, the medication will be given only if the signed permission form is present. The Kuemper staff has the right to deny these medications to a student due to the frequency of use or an invalid complaint.

If the student complaints become frequent or worsen, the parent or guardian will be notified. These medications will not be given to students with a temperature of 100.0 F or higher.

I hereby request the Kuemper nurse, or in the nurse's absence, a person who has successfully completed an administration of medication course, to administer the following non-prescription medications:

Student's name:_____**Circle Grade**: 6 7 8 9 10 11 12

Check one or both of the following medications and **circle** the dose that you would like your middle/high school student to have:

_____**Tylenol (Acetaminophen) 325mg**, (**1 tab**)or (**2 tabs**) every 4 to 6 hours for headache, minor aches, menstrual cramps or tooth pain.

_____ **Motrin (Ibuprofen) 200mg, (1 tab**) or (**2 tabs**) every 4 to 6 hours for headache, minor aches, menstrual cramps or tooth pain.

My child has not experienced any side effects from the selected medication. I agree to allow qualified personnel to dispense the selected medication to my child if it is determined that it is necessary. I understand that I will be notified if my child's condition worsens.

_____

Parent / Guardian Signature Date

(PLEASE RETURN WITH REGISTRATION FORMS. THIS FORM IS TO BE USED FOR ONE STUDENT IN THE HOUSEHOLD. DO NOT PUT MULTIPLE STUDENTS ON THIS FORM. IF MULTIPLE STUDENTS ARE LISTED, THE FORM WILL BE VOID.)