

# The Country School

341 Opening Hill Rd. Madison, CT 06443  
203.421.3113 Ext. 111

USE FOR GRADES

5-8

## Health History Update Academic Year 2010-2011

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical Diagnosis/Conditions: \_\_\_\_\_

Allergies (food, drugs, Environmental, Animals, Insects): \_\_\_\_\_

Medication(s) taken at home: daily: \_\_\_\_\_

As needed: \_\_\_\_\_

Medication necessary at school: \_\_\_\_\_

Annual Medical Update:  Asthma:  mild  moderate  severe  exercise-induced Inhaler needed in school:  Yes  No

Other Pertinent Information: \_\_\_\_\_

*Note: Please Inform the School Nurse promptly if there are any changes in the information provided on this medical form.*

### **Consent For Medication Grades 5-8**

To be administered by the school nurse up to one hour before school dismissal

**ACETAMINOPHEN** (Same as **TYLENOL**) 320-650mg orally every 4 hours.

**OR**

**IBUPROFEN** (Same as **MOTRIN** or **ADVIL**) 1 or 2 tabs (200mg. each) orally every 6 hours.

1. General Pain/discomfort: after assessment, and up to 5 doses per school year.

2. HEADACHE: limit administration to 2 occurrences/month or 3 consecutive days

3. DENTAL PAIN: up to 4 days following dental procedure.

4. FEVER: greater than 101°.

5. MENSTRUAL CRAMPS: limit administration to 5 days/month

If it is necessary to exceed the above limitations, an order will be required from the child's health care provider.

**I grant permission for the school nurse to administer the above dosage of medication to my child in the event of above-mentioned symptoms while at school.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

**I request that NO medication be administered to my child while at school.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Consent For Overnight Field Trip Medication**

Grades 5-8

Medications Overnight Field Trip-PRN

PAIN: Headache, Muscle, Menstrual, and Dental. FEVER: >101F

Acetaminophen (Tylenol Brand) 325-650mg orally every 4 hours

Ibuprofen (Advil, Motrin, brand) 200mg-400mg orally every 6 hours

MOTION SICKNESS: Benadryl 25 mg capsule (1 capsule) orally every 4-6 hours

ALLERGIC REACTION: Benadryl 50 mg (2 tablets-25 mg OR 4tsp-12.5mg/tsp) orally every 6-8 hr.

DIARRHEA: Imodium 2mg-4mg not to exceed 16mg/day.

INDIGESTION: Tums 750mg as symptoms occur.

**I grant permission for my child to receive the above dosage of medication administered by a school faculty member in the event of above-mentioned symptoms while on an overnight field trip.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_