MEDICAL UPDATE FORM
MSAD #29 School year 2015-2016

Parent/Guardian,
In order to bring each student health record up-to-date, this form should be filled out and returned to the school nurse.

STUDENT NAME	DATE OF BIRTH	GRADE	ADVISOR/TEACHER
	/ /		
PARENT/GUARDIAN NAME	HOME PHONE	CELL PHONE	WORK PHONE
	(207)- -	(207)- -	(207)- -

ASTHMA: YES_____ NO_____ IF YES, Will your child require an inhaler at school? YES _____ NO _____

ALLERGIES: YES:_____ NO_____ IF YES, PLEASE LIST ALL ALLERGIES YOUR CHILD HAS, INCLUDING BEES OR OTHER INSECT STINGS, FOOD, MEDICTION, ENVIRONMENTAL, OR OTHER:_____

ALSO, IF YES, DOES YOUR CHILD NEED AN EPI-PEN OR BENADRYL? YES_____ NO_____. IF "YES", PLEASE PROVIDE MEDICATION AN DYOU WILL NEED TO HAVE A MEDICAL AUTHORIZATION FORM FILLD OUT BY YOUR CHILD'S DR.

DIETARY RESTRICTIONS: (Does your child have a special diet for health reasons?) YES_____ NO_____
IF "YES", PLEASE EXPLAIN: _____

DAILY MEDICATIONS: NOTE: Any time your child needs to take prescription or over the counter medication at school, a medication authorization form provided by the school must be completed and returned before school personnel will administer medication.

HEALTH CHANGES/UPDATES: Did your child have any illness, accident, or hospitalization over the summer (past three months)? _____

IMMUNIZATIONS: Has your child received any immunizations in the past year? YES _____ NO_____

Name of Doctor_____Telephone:_____

MEDICATION ADMINISTRATION PERMISSION---OVER THE COUNTER MEDICATION
PLEASE INITIAL EACH MEDICATION THAT APPLIES

____*Reg Strength Tylenol per dosage indicated

___*Extra Strength Tylenol(500mg) 1-2 tabs every 4-6 hrs. as needed for pain

____*Ibuprofen per dosage indicated

____*TUMS or Rolaids, 2-4 tabs as needed, per instruction on bottle

___*Cough Drops as directed for cough
*Parent to supply Tylenol, Ibuprofen, Tums and cough drops

____Itch Relief Gel every 4 hrs. as needed for itching from fly bites or hives

____Triple Antibiotic Ointment as needed for minor scrapes/cuts

____Ora-gel as needed for mouth pain

____Benadryl 12.5-50 mg for minor allergic reaction. (Parent will be notified)

The listed medications will administered only for their intended uses. The school will contact parent/ guardian if further medical treatment is necessary.

These medications will apply during school day setting as well as to field trips.
I give permission for the school nurse and trained qualified staff to administer the indicated medications to my child. This pertains to the current school year only. I give my permission for the school nurse to share important health information with staff members who will be responsible for my child.

Parent/Guardian Signature:
_____
Date:
_____