Fort Zumwalt School District
HEALTH CARE INFORMATION

Dear Parent or Guardian:

The Fort Zumwalt School District, with parent/guardian written consent, will provide basic treatment for minor illness and injury while at school. The district may also administer the following non-prescription, over-the-counter medications, based on nursing assessment, with parent/guardian consent:

Anti-itch
Benadryl cream
Caladryl/Calamine lotion
Hydrocortisone cream 0.5% & 1%
Eye Care
Contact lens solution/lubricating drops
Saline solution eye wash/irrigation
Allergy eye drops
Visine eye drops
Oral/Dental
Anbesol/Orageł
Chapped lip ointment
Sore throat spray
Salt for gargle
Vaseline Petroleum
Dental wax
Wound care
Bactine/Wound care wash
Burn cream
Triple Antibiotic ointment
Miscellaneous
Isopropyl alcohol
Aloe Vera
Baking Soda
Hydrogen peroxide
Non salicylate muscle rub
Sting Kill (for insect bites)
Antacids/Tums
Vaporub

*generic version of all OTC medications are acceptable

Acetaminophen: – registered nurse can give acetaminophen ten (10) times only during the school year for a headache, pain, fever, injury or menstrual pain. **The parent/guardian must give verbal permission**. If your student requires District provided acetaminophen more than 10 times, the parent will have to provide the medication.

Emergency Medication
In an effort to serve the students of the Fort Zumwalt School District, as well as meet the medication guidelines of the State of Missouri and policies set by the School Board, the following emergency medication should be available:

Albuterol: – (aerosol) for asthma related reactions in emergency, potentially life threatening situation

Benadryl tablets/liquid: - for allergic reaction
Age 5-11: Benadryl liquid 1-2 tsp. or 25 mg X1 for allergic reaction without signs of anaphylaxis if parents cannot be reached
Age 12 – 21: Benadryl 1 or 2, 25 mg capsules X 1 for allergic reaction without signs of anaphylaxis if parents cannot be reached

Epi-Pen: emergency use for allergic reaction/anaphylaxis

Glucose testing: supplies for emergency testing of diabetic students only

Oxygen: emergency use

State law requires parental consent in order for the school nurse to treat your child

Please sign the "Health Inventory and Health Care Consent Form"

FORT ZUMWALT SCHOOL DISTRICT
STUDENT HEALTH INVENTORY and HEALTH CARE CONSENT

Student: _____
Last First M.I.

School: _____ Grade: _____ Date of Birth: _____

Sex: ☐ M ☐ F

Check all that apply to your child:

☐ ADD / ADHD Medication? ☐ Specify Med:

☐ Allergies, food Epi Pen? ☐ Specify Food: ***Additional forms required

☐ Allergies, insects Epi Pen? ☐ ***Additional forms required

☐ Allergic Reaction to Medications

☐ Allergies, other Specify:

☐ Asthma: Medication? ☐ Specify Med: ***Additional forms required

☐ Mild ☐ Moderate ☐ Severe

☐ Diabetes - Please provide Dr. contact information: ***Additional forms required

☐ Does your child use hearing aides or have a cochlear implant?

Additional Information:

☐ Does your child wear glasses or contacts? Fulltime ☐ Just for reading ☐

Additional Information:

☐ Epilepsy / seizures Additional Information: ***Additional forms required

☐ Heart condition / disease Additional Information:

☐ Mental / emotional condition Additional Information:

Under care of mental health professional? ☐ Name:

☐ Migraines Medication? ☐ Specify Med: Bring to school ☐

☐ Neurological Disorder Specify:

☐ Skin condition Specify:

☐ Orthopedic problems Specify:

☐ Wheelchair ☐ Leg braces ☐ Walker

By signing this form, I give school permission to treat my child for minor illness, injury while at school, using the OTC products listed on the Health Care form available in my packet and on the District web site.

Ft. Zumwalt will provide routine vision and/or hearing screenings for all students in grades K – 5 and grade 7.

COMPLETE AND SIGN ON REVERSE SIDE

**District policy requires a doctor's signed, written request for administration of prescription medication.*

MEDICATIONS: taken at school? Please list: ***Additional forms required

1.
2.
3

MEDICATIONS: taken at home? Please list dosage and times:

1.
2.
3

Has your child had a recent serious illness/hospitalization?

Specify:

Does your child need:

☐ Restricted physical education (need Dr. note)
☐ Special seating

Other conditions the school should be aware of:

1.
2.
3

Local Physician's name & telephone number

Name Address Telephone

In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me I hereby authorize the school to take the steps necessary to insure the well being of the above-named child, which may include calling 911. If the parent(s)/guardian(s) cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parent(s)/ guardian(s). This information is confidential and will be shared with school personnel when deemed necessary.

NOTE: Please keep the office informed of current emergency contact information.

Signature of Parent / Guardian (Required) Relationship Date

By signing this form, I give school permission to treat my child for minor illness, injury while at school, using the OTC products listed on the Health Care form available in my packet and on the District web site.

You will be requested to complete and update the Student Health Information and Health Care Consent form annually.

FORT ZUMWALT SCHOOL DISTRICT

Request for Parent Provided Over-the-Counter Medications to be taken at school

The parent/guardian must complete the following request form for administration of over-the-counter medication. Parent must provide the medication in the original manufacturer's bottle or container. Medication dosages will be given according to the manufacturer's label.

Student Name: _____ Teacher/Grade: _____

DOB: _____

Medication: _____ Dosage: _____

Time to be given: _____

Reason for Administering: _____

Are there any known allergies to the medication? Yes ☐ No ☐

If yes, explain: _____

To be administered: from _____ (date) to _____ (date)

Is your child currently taking any medication or herbal preparation? Yes ☐ No ☐

If yes, please name: _____

Parent/Guardian Signature: _____

Date: _____

Daytime Telephone Number: _____

School Building: _____

PLEASE BE AWARE: Except for inhalers, medications will NOT be sent home on the school bus. Students who drive may take home any over the counter medications. Any leftover medications will be destroyed at the end of the school year.

Rev: 2/9/15

ADMINISTRATION OF MEDICATIONS TO STUDENTS
(Physician Certification)

I certify that I am a licensed physician authorized by law to prescribe medication.

I have prescribed or ordered _____(medication)

for _____(student's name)

to treat/manage_____(condition).

I further certify that:

- I have instructed Student in the correct and responsible use of Medication.
- I have attached a treatment plan for managing Student's Condition.
- Student is capable of self-administering Medication in accordance with the treatment plan and has demonstrated to me or my designee the skill level necessary to self-administer Medication.

_____
Printed Name of Physician

_____
Signature of Physician

_____
Date

Adopted: 11/19/2007