Annual Health Questionnaire and Consent for Administration of Approved Discretionary Medications 2021-2022

Student Name:_____ **Date of Birth:**_____

School/Division:_____ **Grade:**_____ **Age:**_____ **Weight:**_____

Home Phone:_____ **Cell Phone:** _____

Medical/Health Information:

Doesyour child have any allergies (food, environmental, etc.) or asthma? _____

_____

Please describe your child's allergic reaction(s). Be very detailed and specific. For example: Does she experience rash or hives? Does she experience difficulty breathing, swelling, or anaphylaxis? Is your child asthmatic or have a history of reactive airway? Is her asthma allergy-induced, exercise-induced, or both? What is your physician's recommended intervention? ***Be sure to enclose a medical order for whatever intervention is recommended (i.e., Epi-Pen, Albuterol, etc.).***

_____

_____

Please list any medications or treatments your child takes at home (dosage, time, and purpose)_____

_____

Baltimore County regulations prohibit school personnel from administering Tylenol or *any* other over-the-counter medication without written medical authorization from your physician *and* written permission from the parent.

I_____**DO** give permission to the Health Suite personnel to administer medications to my child.
I_____**DO NOT** give permission to the Health Suite personnel to administer medications to my child.

I would like the following medication(s) made available to my child: *(please check medication and dosage)*

For Headache/Fever/Burns/Earache/Muscle Aches/Pain
Acetaminophen (Tylenol) ___160/mg/5 ml liquid_____160 mg chewables _____325 mg tab
Ibuprofen (Advil) ___100 mg/5 ml liquid ___200 mg tab
For Upset Stomach ___chewable Antacid (Tums) 500 mg
For Allergic Reactions ___Diphenhydramine (Benadryl)____12.5 mg syrup____12.5 mg chewable tab
For Coughs/Sore Throats ____Throat Lozenge
For Cuts/Scrapes ____Antibiotic ointment
For Bites/ Itching ____Hydrocortisone 1% cream
For Sun Protection ___sunscreen

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

_____ _____
Signature of Physician **Printed Name of Physician** **Date**