



SIGNATURE REQUIRED on back/page 2

HEALTH INFORMATION & AUTHORIZATION FOR HEALTH CARE

Grade (2011-2012): \_\_\_\_\_

Black or Blue Ink Only (To be submitted annually)

Student's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Parent/guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Physician/NP: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

Host Parent(s) \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Local/Emergency contacts: Please list at least two local people we can contact (if we cannot reach a parent/guardian) when a student is ill/injured: needing to leave school...needing emergency care...or wanting permission to walk/drive home.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Health/Accident Insurance Policies: It is required that all students have health insurance. If you need assistance with this, contact the Health Service Office (846-9051) ext 402

Name of Health Insurance Company \_\_\_\_\_

Subscriber's name, and company name: \_\_\_\_\_

ALLERGIES: Medications: \_\_\_\_\_ Reaction: \_\_\_\_\_

Food: \_\_\_\_\_ Reaction: \_\_\_\_\_

Bees/Insects: \_\_\_\_\_ Reaction: \_\_\_\_\_

Other: \_\_\_\_\_ Reaction: \_\_\_\_\_

Epi-pen at school: Yes No

ASTHMA: \_\_\_\_\_ Inhaler at school: Yes No

Student's name: \_\_\_\_\_

**OTHER HEALTH CONCERN:** \_\_\_\_\_

It is important that when providing care, the NYA Health Service Office and Emergency Health Providers have **CURRENT** health information including significant health concerns and medications. If changes occur during the school year, please contact the Health Service Office 846-9051 ext 402.

**SIGNIFICANT HEALTH HISTORY OR RESTRICTIONS:** (i.e. asthma, diabetes, orthopedic, gastrointestinal, emotional and or learning disabilities). **If more space is required, attach additional paper.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS:** Please note whether medications are taken at home or school.

- If a student requires medication (prescription or over-the-counter) during school hours, a parent **MUST** notify the Health Service Office, discuss the plan for administration and complete appropriate forms.
- Medication **MUST** always be in the original labeled container. Students are **NOT** allowed to carry medication: prescription or over-the-counter, unless authorized by the Health Office and with a physician's order

MEDICATION	Dose & Frequency	Purpose	Home	School

**AUTHORIZATION FOR FIRST AID AND ADMINISTRATION OF SPECIFIED OVER-THE-COUNTER MEDICATIONS:**

The following over-the-counter medications are available for students through Health Services. Please designate permission to administer, with an "x" by each choice. I hereby authorize school personnel (school nurse, designated persons on NYA campus or faculty/staff/coach/adult chaperone when off campus: NOT always a nurse.) to provide first aid and administer designated over-the-counter medications – (prn = as needed). **IF THERE IS NO MARK, IT IS ASSUMED THERE IS NOT PERMISSION TO ADMINISTER**

Medication	Dose & Frequency	Purpose	Yes
Acetaminophen/Tylenol	650 mg, every 4 hours prn	headaches, mild pain	
	1000 mg, every 4 hours prn	older student, moderate pain	
Ibuprofen/Advil/Motrin	400 mg, every 4 hours prn	headaches, mild pain	
	600 mg every 4 hours prn	older student, moderate pain	
Phenylephrine HCL/Sudafed	10 mg every 4 hours prn	decongestant for colds/allergies	
Diphenhydramine/Benadryl	25 mg every 6 hours prn	mild allergic reactions	
	50 mg every 6 hours prn	moderate allergic reaction	
Tums	2-4 every 4 hours prn	antacid for upset stomach	

**EMERGENCIES AND RELEASE OF INFORMATION:**

In the event of an emergency, I authorize transport to an emergency facility and any medical and/or surgical treatment for the student deemed advisable in the diagnosis and treatment of an illness or injury. Every attempt will be made to contact parent/guardian in the event of an emergency. I also authorize release of information on this form to any designated persons including but not limited to coaches, athletic trainer, field trip chaperones, health insurance companies, and healthcare providers as needed in an emergency. I acknowledge that this form will be copied (placed in a non-revealing envelope/binder to assure confidentiality) for the purpose of providing availability of information when the student is off campus for field trips, athletic events or other school related activities. Original is stored in the Health Service Office and copies will be located in the Main Office and Middle School Office and areas designated by The Crisis Management Team.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_