# *LAKE OCONEE ACADEMY*

## *Health Information / OTC Medication Administration Form*

Name_____ Grade _____ DATE: _____

*Last* *First* *Middle*

***Health Information***

Is this student taking any medications at home? ____ Yes _____ No *If yes, please list here:* _____

_____

Does this student have any known **DRUG Allergies**? ____Yes _____ No *If yes, please list here:* _____

**Allergies to:**

**Foods:** _____ Reaction: _____
**Insects/ Stings:**_____ Reaction: _____
**Seasonal:** _____ Reaction: _____
**Latex:** Allergy _____Yes _____ No Sensitivity _____Yes _____ No Reaction: _____
**Other:** _____ Reaction: _____

Hearing impairment? _____**Yes** _____ **No** *If yes, use hearing aids at school?* _____**Yes** _____ **N**o
Visual impairment? ____**Yes** ____ **No** *Glasses?*____ **Yes** ___**No** *Contacts?* ___ **Yes** ____**No**

**DOCTOR'S NAME** _____ **PHONE** _____

**Circle Any Current/ Past Conditions:** *Cardiac Issues* *Asthma/ Respiratory Problems* *Seizures* *Cancer*

*Hypoglycemia* *Diabetes* *Bleeding Disorders* *Sickle Cell Disease* *Migraines* *Head Injury/ Concussion*

Please list details of the above conditions or any other medical concerns or physical disabilities that will allow us to better serve your student: _____

_____

**My signature below grants the school nurse permission to share medical information with EMS and/ or school personnel as necessary to ensure my child's safety & well being. And to contact my child's physician for further information if necessary for the health and welfare of my child while on campus at Lake Oconee Academy.**

➤ **Parent / Guardian Signature** _____ **Date** _____

### *OTC Medication Administration*

I, _____, the parent/ guardian of _____, hereby authorize the school nurse to dispense over- the- counter medication(s) below to my child, if deemed necessary and appropriate, with the exception of those medications next to which I have placed a check mark. By agreeing to allow administration of these medications, I agree to take responsibility for any side effects/ adverse reactions and hold neither the nurse, LOA nor the Greene County School System liable.

*TYLENOL _____ IBUPROFEN _____ ANTIBIOTIC OINTMENT _____ TUMS/MYLICON _____ BUG STING RELIEF _____*

*COUGH DROPS_____ HYDROCORTISONE CREAM _____ BENADRYL (oral) _____ (cream)_____ EYE DROPS _____*

➤ **Parent / Guardian Signature _____ Date _____**

*Complete the line below if you wish to be notified prior to administration of the above items.*

***PLEASE CALL _____ AT _____-_____-_____***

**Information on this form is collected under the Authority of the Education Act & Regulations for the purpose of maintaining student records. This information may be used by administrators, teachers, nurses, support staff & supervisory officers of the Greene County School System. I hereby certify the information herein is correct to the best of my knowledge.**

➤ **Parent / Guardian Signature** _____ **Date** _____

Updated 5/2023