LAKE OCONEE ACADEMY

Health Information / OTC Medication Administration Form

SCHOOL YEAR 2018 -19

Name_____ Grade _____ Homeroom _____
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 Allergies? ____Yes _____ No *If yes, please list here:* _____

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

Does student have a hearing impairment? **_____Yes _____ No** *If yes, uses hearing aid at school?* **_____Yes ___ N**o
Does student have a 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 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) initialed below to my child if deemed necessary and appropriate. In so doing, 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 _____ NEOSPORIN _____ TUMS _____ BUG STING RELIEF _____

HYDROCORTISONE CREAM _____ BENADRYL (oral) _____ (cream)_____ VISINE _____ GAS-X _____

➢ **Parent / Guardian Signature** _____ **Date** _____

Complete the line below if you wish to be notified prior to administration of the medications you initialed.
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 os the Greene County School System. I hereby certify the information herein is correct to the best of my knowledge.

➢ **Parent / Guardian Signature** _____ **Date** _____

Form updated 8/2018