Preschool Medical Release Form

School Year: _____

Student's Name: _____ Grade: _____

Father's Name: _____ Mother's Name: _____

Address: _____

Home Phone: _____Father's Cell: _____ Mother's Cell : _____

Student lives with? ❒ Both Parents ❒ Mother ❒ Father ❒ Guardian ❒ Foster Home

Please number in order of preference your desired procedure in the case of illness or injury:

( ) Contact Father's Employer: _____ Phone: _____

( ) Contact Mother's Employer: _____ Phone: _____

( ) Emergency Contact Person: _____ Phone: _____

( ) Emergency Contact Person: _____ Phone: _____

* One of the above **must** be available to pick up the child if he/she has to go home.

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Does this child have food allergies? ❒ No ❒ Yes

If yes, please specify: _____ Type of reaction: _____

Does this child have drug allergies? ❒ No ❒ Yes

If yes, please specify: _____ Type of reaction: _____

Is an Epi-pen required/prescribed by a doctor? ❒ No ❒ Yes

Does your child carry an Epi-pen with him/her? ❒ No ❒ Yes If yes, Doctor's Order (school form) is needed. Parent is responsible for providing the Epi-pen.

Does this child have asthma? ❒ No ❒ Yes If yes, list triggers/symptoms: _____

Has your doctor prescribed an inhaler? ❒ No ❒ Yes If yes, list name of inhaler: _____

If yes, Doctor's Order (school form) is needed. Parent is responsible for providing medication to the school.

Does this child have chronic or medical conditions/illnesses? If yes, check: ❒ Seizures ❒ Diabetes (❒ Type 1 or ❒ Type 2) ❒ Cardiac Condition ❒ Other, specify _____

Please list any other important information to help us better care for your child while at school: _____

_____

_____

_____

Please list medications & reason for taking at home: _____

Please list medications & reason for taking at school: _____

* All prescription medications that need to be given during school hours must have a Doctor's Order (school form) and be kept in the nurses' office.

(Over)

The following are the approved over-the-counter medications that may be administered at school. Please check yes or no as to whether your child may be given these medications:

Medication/Dosage	Yes	No	Medication/Dosage	Yes	No
Tylenol/acetaminophen, as directed for weight & age			Tums, one tablet up to four times a day		
Motrin/Advil/ibuprofen, as directed for weight & age			Solarcaine spray for burns, apply as needed		
Non-drowsy Robitussin cough syrup, as directed for weight & age			Triple Antibiotic Ointment, apply as needed		
Cough drops or lozenges, one as needed			Calamine/Caladryl lotion, apply as needed		
Benadryl for allergic reactions (hives, rash, itching, sneezing, runny nose), as directed for weight & age			Phenylephrine HCL/Non-drowsy Pseudoephedrine free/Nasal Decongestant tablets/liquid, as directed for weight & age		

Medical Permission for School Health Services

- I hereby give permission for my child to receive the following medical attention as part of the state-mandated regulations and school health program:
  - Height and weight annually; K – 12
  - Vision screening annually; K – 12
  - BMI ratio and BMI percent; K – 12
  - Hearing screening; K, 1, 2, 3, 7, & 11
  - Scoliosis screening examinations; 6 & 7
  - Random head lice screening
  - Puberty informational talk and video; 5
- Each year the school nurse prepares a confidential list that includes students who have significant health concerns. This confidential list is shared with staff for the sole purpose of protecting the health and well being of the student. By signing below you allow the nurse to share any information deemed appropriate.
- If a parent cannot be notified, and emergency care is necessary, I hereby give my permission for this student to be transported to the nearest hospital and I give permission for the hospital to give emergency treatment as may be needed. I will assume responsibility for fees incurred by such an emergency.

Parent's/Guardian's Signature: _____ Date: _____