Dear Parent/Guardian:

The attached papers need to be filled out and returned as soon as possible. Some of the questions probably seem a little personal, but these are things that the state requires answers on a yearly basis. When these questions are asked, overall numbers, not names are being looked for. All information received will be kept confidential. It is very important that you complete ***ALL*** questions to the best of your knowledge.

During the school year we keep on hand the over the counter medications listed below for treating everyday injuries/ailments of the students. By signing this form you are giving your permission for the staff at Hume School to use any/all of these at our discretion. If there is any that you do not wish for your child to have, please cross out those medications on this list.

Prescription medications can only be given if the school has a signed permission slip from the physician, signed consent form from the parent/guardian, and a labeled bottle containing the medication. Medications in zip lock bags or other containers will not be accepted. No early a.m. meds will be given. Please give these at home before the students leaves your residence. Signing of this form gives the staff permission to give prescription meds that your physician has prescribed.

Thank you,

Sharyl Dale RN

Student Name____

Parent/Guardian Signature____

Date____

MEDICATION LIST:

Aloe Gel with lidocaine
Calamine lotion
Hydrogen Peroxide
Cough Drops
Triple Antibiotic cream
Tylenol & Motrin products
Daytime Cold & Flu
Chloraseptic throat spray
Throat Lozenges
Pepto Bismol
Artificial tears
Hydrocortisone cream 1%
Latex band-aids
Saline Solution
Anbesol
Benadryl products
Vaseline
Ibuprofen
Cortaid
Tums

Has your child seen a physician in the past year?____________If yes, who___________________

Has your child seen a dentist in the past year?______________If yes, who___________________

Is your child allergic to any food, insect, or medications? If so list:__________________________

Has your child seen a physician in the past year for any of the following:
Asthma_________
Seizures_________
ADD/ADHA_____
Diabetes________
If other list____

Insurance Information (check one):
Private_______Medicaid_______No Insurance________

Mother's Name____________________ Home Tele. Number________________
Work Tele. Number_________________

Father's Name_____________________Home Tele. Number_________________
Work Tele. Number_________________

Emergency names and numbers if parent cannot be reached:
Name______________________________
Telephone Number_________________________
Relationship to student_________________________

Name of Doctor & Number______________________Date of Last Visit_________

Name of Dentist ______________________________Date of Last Visit_________

Is your child allergic to any **food, insect, or medications**? If so list____

Does your child take any medications on a regular basis? If so list____

Any other health conditions/concerns the nurse and staff should be aware of____
____

Does your child have any of the following diagnosis?
Asthma_____
Seizures_____
ADD/ADHD___
Diabetes____
None of the above ____

INSURANCE INFORMATION (check one):
Private_____ Medicaid_____ No Insurance_____

Parent Signature:__________________ Date_____________

AUTHORIZATION FOR MEDICATIONS

Hume R-V111

To parents or gaurdians: If it is necessary for your child to take medications during school hours, this form MUST be completed and on file in the school office. Please have the physician fill out the sections that apply to your child. All medicine is to be in the original container..

Student's Name____________________ Grade__________
Parent's Name_____________________ Day Phone#______________
Physician's Name, Address,______________________________________
Phone#____

I. **PRESCRIPTION DRUGS:**

NAME OF MEDICATION:________________DOSAGE____________
Purpose of medication:____
Date to begin:_________________________ Date to end______________
Times to be given:____
Possible side effects:____
Are there any restrictions: Yes____ No____ If yes, what and how long:____
Parent's Signature________________________ Date _________________
Physician's Signature______________________ Date_________________

II. NON-PRESCRIPTION DRUGS

Name of Medication____
Dosage and Time ____
Date to begin ____________________________ Date to End___________
Parent's Signature ________________________ Date _________________
Physician's Signature_______________________ Date _________________

III
SELF-ADMINISTERED DRUGS**

Name of Medication ____
Dosage ____
Parent's Signature _________________________ Date__________________
Physician's Signature ________________________ Date_________________

** Hume R8 School is not responsible for self-administered medications.