

BROOKLYN FRIENDS SCHOOL

Confidential Student Health Form 2010-11 School Year

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The School will act based on the information you provide. It is expected that this form is accurate, complete and up-to-date. X indicates a signature is required. Both Part I and Part II must be completed as part of the student's health record.

Part I: To be completed/signed by parent/guardian

Student's grade in Sept '10: _____

Student

Name _____ Gender _____ Date of Birth ___/___/___
LAST FIRST MIDDLE mo. day year

Parent/Guardian Name _____

E-mail _____

Parent/Guardian Phone Numbers:

Home _____

Cell _____

Work _____

Parent/Guardian Name _____

E-mail _____

Parent/Guardian Phone Numbers:

Home _____

Cell _____

Work _____

Emergency Contact in the event BFS is unable to reach parent(s):

Name: _____ Phone: _____ Relationship: _____

EMERGENCY CARE AUTHORIZATION: I give my permission for the school to administer first aid to my child as needed. I give permission for the school to contact my child's physician for medical instructions. In the event that I cannot be reached and emergency hospital care/treatment is needed, I give my permission for my child to be taken to the nearest hospital and given the necessary care.

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

CONSENT TO SHARE INFORMATION: I give my permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

PERMISSION TO ADMINISTER NON-PRESCRIPTION (OVER THE COUNTER OTC) MEDICATION TO STUDENT

The School Nurse MAY NOT administer any OTC medication to my child.

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

Authorization is given to the School Nurse to administer those OTC medications I have checked below. I understand that medication will be administered based on the child's weight. **I also understand that the signature of my child's physician is required for OTC medications to be dispensed by the School Nurse.**

Acetaminophen (Tylenol) – 325mg tablets

Acetaminophen Chewable Tablets, 80mg

Acetaminophen Liquid 80mg/5ml

Benadryl capsules (25mg)

Benadryl Liquid 12.5mg/5ml

Cepacol Lozenges

Ibuprofen (Motrin, Advil) – 200mg tablets

Ibuprofen Liquid (Motrin, Advil) 100mg/5ml

Tums

Polysporin topical ointment

Hydrocortisone 1% topical cream

First Aid burn gel topical gel

Sun block/lotion

X PARENT/GUARDIAN SIGNATURE _____ DATE _____

X PHYSICIAN SIGNATURE _____ DATE _____

If your child has been diagnosed with asthma, allergies, or any other chronic illness requiring treatment or medication, it is school policy for parents/guardians to make an appointment with the School Nurse to discuss treatment plans and to fill out other necessary forms (ALLERGY ACTION PLAN, ASTHMA ACTION PLAN, PRESCRIPTION MEDICATION FORM, SELF-MEDICATION FORM) before the first day of school. Forms are on the BFS Website. No student may self-medicate or carry on his/her person any OTC or prescription medications (this includes inhalers and epi-pens) without clearance/authorization from the School Nurse. Note: Both Part I and Part II of this Confidential Student Health Form must be completed.

Part II: To be completed/signed by physician/health care provider

Student Name _____ Date of Birth ___ / ___ / ___
LAST FIRST MIDDLE mo. day year

Date of Physical Exam: _____ Grade in Sept '10: _____

Height: _____ Weight: _____ Body Mass Index: _____ Blood Pressure: _____

General Appearance:

<input type="checkbox"/> Nl	<input type="checkbox"/> Abnl	<input type="checkbox"/> Nl	<input type="checkbox"/> Abnl	<input type="checkbox"/> Nl	<input type="checkbox"/> Abnl	<input type="checkbox"/> Nl	<input type="checkbox"/> Abnl	<input type="checkbox"/> Nl	<input type="checkbox"/> Abnl
<input type="checkbox"/>	<input type="checkbox"/> HEENT	<input type="checkbox"/>	<input type="checkbox"/> Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/> Skin	<input type="checkbox"/>	<input type="checkbox"/> Psychosocial
<input type="checkbox"/>	<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral

Describe abnormalities: _____

Physical Maturity: (Tanner Stage): I. II. III. IV. V.

Does the student have a past or present medical history of the following:

- | | | | | |
|-------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Asthma* Severity: | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Mild Persistent | <input type="checkbox"/> Moderate Persistent | <input type="checkbox"/> Severe Persistent |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> Life-Threatening Allergy * | | | |
| <input type="checkbox"/> Chronic or recurrent otitis media | <input type="checkbox"/> Orthopedic injury/disability | | | |
| <input type="checkbox"/> Congenital or acquired heart disorder | <input type="checkbox"/> Seizure disorder | | | |
| <input type="checkbox"/> Developmental/learning problem | <input type="checkbox"/> Speech, hearing, or visual impairment | | | |
| <input type="checkbox"/> Diabetes * | <input type="checkbox"/> Tuberculosis (latent infection or disease) | | | |
| <input type="checkbox"/> OTHER (specify) | <i>Please explain all checked items on an addendum</i> | | | |

Allergies * (Food, Drug, Environmental) _____

* **Action Plan and/or Medication Administration Form Required**

Dietary Restrictions: None Yes (list): _____

Screenings: Vision: R Corrected _____ Uncorrected _____ Hearing: Normal Abnormal
 L Corrected _____ Uncorrected _____ Scoliosis: Negative Positive

Lead: (0-10) _____ PPD/Mantoux Date Placed _____ Date Read _____ Neg Pos

IMMUNIZATIONS - PROVIDE DATES BELOW OR ATTACH SEPARATE SHEET

Hep B _____	Varicella _____
Rotavirus _____	Td _____
DTP/DTaP/DT _____	Tdap _____
Hib _____	Hep A _____
PCV _____	Meningococcal _____
Polio _____	HPV _____
Influenza _____	Other _____
MMR _____	

Physician/Health Provider, PLEASE CHECK APPROPRIATE BOXES AND SIGN BELOW:

- This student may participate fully in school physical activities including team sports, PE, and dance classes.
 This student has the following physical restrictions: _____
 OTC medications as indicated by parent/guardian in Part I may be administered as per package protocol.

Provider's Name: _____

Provider's stamp: _____

Address: _____

Phone: _____

✕ Signature: _____ Date _____