



# St. John's Lutheran School

## Health and Medication Form

### 2022-2023

Equipped · Engaged · Encouraged

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

No School personnel shall administer any prescription or non-prescription medication unless the school has the student's current and complete Health and Medication Form on file. All prescription medication must have doctor's orders included. If doctor's orders are not included, orders may be faxed from the doctor's office. **Allergy plans must be updated each school year.**

A Health and Medication Form is distributed for each student at registration. The Health and Medication Form is also available in the school office and on our website.

1. Does your child have any food allergies? If yes, please note allergy and treatment:  
\_\_\_\_\_  
\_\_\_\_\_ 1. Yes \_\_\_\_\_ No \_\_\_\_\_
2. Is your child allergic to insect stings? If yes, please note reaction and treatment:  
\_\_\_\_\_  
\_\_\_\_\_ 2. Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does your child have asthma? If yes, please note medication and restrictions, if any:  
\_\_\_\_\_  
\_\_\_\_\_ 3. Yes \_\_\_\_\_ No \_\_\_\_\_
4. Is your child on any medications? If yes, please specify:  
\_\_\_\_\_  
\_\_\_\_\_ 4. Yes \_\_\_\_\_ No \_\_\_\_\_
5. Does your child need medication in school? If yes, please complete the Medication Permission section. (see reverse side)
6. Does your child have any health concerns of which the school should be made aware? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_ 6. Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICATION PERMISSION**

\_\_\_\_\_

Medication/Treatment

\_\_\_\_\_

Time(s) to be administered

May student self-administer medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Please check all that apply:

ASTHMA \_\_\_\_\_ EPI-PEN AUTO INJECTOR \_\_\_\_\_ DIABETES \_\_\_\_\_

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

Yes \_\_\_\_\_ No \_\_\_\_\_

I also request that this student be allowed to carry the above-described medication on their person during school hours and school related activities in order to facilitate the self-administration of the medication as needed. Yes \_\_\_\_\_ No \_\_\_\_\_

**IBUPROFEN OR ACETAMINOPHEN CONSENT**

I do not give my permission, please call first \_\_\_\_\_

I give my child permission to be given:

\_\_\_\_\_(1, 2, or 3—please circle dosage) jr strength (**age 2-11**) generic **ibuprofen** chewable tablets every 6 hours according to dosage instructions on label.

\_\_\_\_\_(3, 4, or 5 please circle dosage) jr strength (**age 2-11**) generic **acetaminophen** chewable tablets every 4 hours according to dosage instruction on label

\_\_\_\_\_ **I understand children 12 and older will not receive chewable tablets unless brought from home**

\_\_\_\_\_(1 or 2) **200 mg** adult strength tablets of generic **ibuprofen** every 6 hours

\_\_\_\_\_(1 or 2) **325 mg** adult strength tablets of generic **acetaminophen** every 4 hours

Parent Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_