BENWAY SCHOOL
2021-2022 SCHOOL YEAR

2A.

STUDENT MEDICAL INFORMATION

Student Name _____ **Date** _____

Address _____ **Home #**_____

_____ **Blood Type**_____

Date of Birth _____ **Soc. Sec.#** (optional) _____

⇒ MEDICAL HISTORY

Please check all diseases your child has had:

_____ Measles	_____ Mumps	_____ Chicken Pox	_____ Whooping Cough
_____ Diptheria	_____ Heart Disease	_____ Hepatitis	_____ Kidney Disease
_____ Rheumatic Fever	_____ Diabetes	_____ Meningitis _	_____ German Measles
_____ Scarlet Fever	_____ Sickle Cell	_____ Lyme Disease	_____ Neuromuscular Disorders
_____ Other:_____			

PLEASE LIST FOOD, MEDICATION OR OTHER ALLERGIES/SENSITIVITIES_____

_____

Does your child have asthma as diagnosed by a physician?_____ **If yes, please explain:**

_____

Does your child have a history of seizures? _____**If yes, type?**_____

Date of last seizure:_____

⇒ MEDICAL INSURANCE INFORMATION

Insurance Company_____ **Policy No.**_____

Whose Name (Parent/Guardian) is Medical Insurance under?_____

* **IF YOU DO NOT HAVE MEDICAL INSURANCE, CAN WE GIVE YOUR CONTACT INFORMATION TO NJ FAMILY CARE SO THAT YOU MAY RECEIVE INFORMATION ON HEALTH INSURANCE? Yes____ No____**

⇒ CURRENT MEDICATION

Please list ALL medications your child is taking at home or school — including inhalers and over-the-counter medications

TYPE	DOSE	TIME GIVEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

* **I authorize required emergency room treatment for my child until we arrive at the hospital. Yes___ No___**

* **For the safety of my child, I authorize the nurse to share important health info with staff. Yes___ No___**

Parent/Guardian Signature_____

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2B.

MEDICATION CONSENT FORM

If, during the school year, it is necessary for your child to receive medication during the school day, you will need to adhere to the regulations outlined below:

- **In order for your child to receive ANY medication during the school day, your child's physician must complete the form below.**
- **This includes:**

1. **All prescription medications (Ritalin, Clonidine, Tegretal, Epi-pen, etc.)**
2. **Any asthma medications, including inhalers and nebulizers.**
3. **Any medication that would be required for a brief period of time, such as antibiotics, allergy medications, etc.**

- **All medication must be sent to the school IN THE ORIGINAL CONTAINER with the appropriate label attached. IF THE MEDICATION IS *NOT* PROPERLY LABELED, IT WILL NOT BE GIVEN.**
- **The parent/guardian must sign this form, granting permission to administer medication to him/her child during the school day.**

ABSOLUTELY no medication will be given if this form is not completed

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PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

Student Name _____ Date of Birth_____

I hereby request that the following medication be administered in school to the student mentioned above.

Name of Medication_____Dosage_____

Time/Circumstances of Administration_____

Diagnosis/Purpose_____

Length of Treatment: From:_____To:_____

Possible Side Effects_____

Special Instructions_____

In the event that the morning dose of this medication is forgotten, may this dose be administered at school after verifying this with the parent? Y N Please list if dose is different from above_____

May medication be given later than the prescribed time in the event that the student is out on a field trip? Y N Please list the latest time the prescribed dose can be given ____

_____ _____ _____ _____

Physician's Signature Date Parent/Guardian Signature Date

Physician's Name (Print) _____Phone_____

Address_____

Your signature provides consent to administer medication at school and to consult with the physician in the event of any concerns that may arise pertaining to the medication.