SWAMPSCOTT PUBLIC SCHOOLS
School Health Services

Permission to treat with Over-The-Counter Medications

Our School Nurses have authorization to administer only the medications listed below. **Any other over-the-counter medication that is not listed on this form will require a Medication Authorization form signed by both you and your child's physician before it can be given in school.**

A parent or guardian must **check off each individual medication** that is authorized to be given to your child, and **sign** the bottom of this form. All medication doses are given according to your child's age and weight as directed by the standing orders and the medication label. The School Nurse will attempt to contact a parent/guardian of Students in Pre School and/or Elementary School prior to administration.

**Check off each that apply:

_____Acetaminophen- fever over 100/mild to moderate pain/headache relief

_____ Ibuprofen fever over 100/mild to moderate pain/headache relief

_____Calcium Antacid for relief of acid indigestion or upset stomach

_____Cough Drops – menthol or other non-medicated for cough or general / throat irritation

_____Diphenhydramine-mild allergic reaction/hives to unknown allergen,

I give permission to the School Nurse to administer the medications listed above to my child during school if necessary

Student's Name (please print) _____
Grade_____

Parent/Guardian Signature
_____**Date:**_____

SWAMPSCOTT PUBLIC SCHOOLS
Swampscott, Massachusetts

Dear Parent/Guardian:

In order for staff to respond appropriately and promptly should a medical problem arise concerning your child, **please answer the questions on the "Update of Student Medical Information" form** and return it to the school. The information may also be shared with your child's teacher, recess and / or lunch monitor.

If there is information which you feel should remain confidential, please specify, and it will not be shared.

Please add any explanations or descriptions that would help us to better understand a situation or problem. This information will be kept in your child's Health Record. Notify the school if there should be any changes during the school year so that your child's Health Record will be kept up to date.

NOTE:
If your child is involved in any before school, after school, Extended Day and / or Swampscott Public Schools athletic activity, it is the responsibility of the parent / guardian to alert the adults & coaches about a serious or life threatening allergy, illness, or condition.

Your prompt reply will be appreciated. Thank you for your continued co-operation.

Sincerely,

Mary Beth O'Malley BSN NCSN
School Nurse

PLEASE COMPLETE "UPDATE OF STUDENT MEDICAL INFORMATION" FORM ON NEXT PAGE

School _____ Grade _____/HomeroomTeacher_____

Swampscott Public Schools

Update of Student Medical Information

Student's Name: _____ Date of Birth: _____

Address: _____

Parent / Guardian #1 _____ Home #: _____
Address_____ Cell#_____
Place of Work_____ Work # _____

Parent/Guardian #2 _____ Home #_____
Address_____ Cell # _____
Place of Work_____ Work #_____

Physician_____ Physician Tel #_____

Dentist: _____ Dentist Tel #: _____

Health Insurance_____

Does your child:

Wear glasses? _____ Full time? _____ Part time? _____
Have a hearing problem? _____ Have frequent ear infections? _____Tubes? _____
Have an orthopedic problem? _____
Have asthma? _____
Have a history of seizures? _____
Have diabetes? _____
Have a heart murmur? _____Any restrictions? _____

Is your child allergic to:

Bees? _____Need Medicine/EPIPEN? _____
Food? _____Need Medicine/EPIPEN? _____
Environment? (dust, pollen, animals)_____
Other? _____

Is your child taking any medication on a regular basis? _____
If so, for what reason? _____
Name of drug: _____

Is there any medical or emotional condition that the school should be aware of?

_____

Is there any family situation (example: military deployment, separation, recent death) that the school should be aware of? _____

Date of last physical exam: _____last dental exam: _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.
I give permission to exchange information with my child's primary physician for the purpose of referral, diagnosis and treatment.

Parent / guardian signature: _____Date: _____

If there is information which you feel should remain confidential, please specify, and it will not be shared.
Information re: a life-threatening condition will be shared with Swampscott Emergency Responders.
Parents are responsible for notifying after school, Extended Day and coaches of this important information.