

Dobyns-Bennett High School Band Medical Form

Grade: _____

2009-2010

This form is required for ALL BAND and COLOR GUARD students!

A parent / guardian must complete ALL items on this form.

FRESHMAN are to bring completed forms to Freshman Band Camp on the FIRST DAY of camp.

ALL other students are to bring completed forms during mandatory drop-in registration.

For More Information Contact:

DB Clinic at #378-8595 or #378-8404; Nursing Supervisor at #956-7514.

Student's Name: _____ (Last) (First) (Middle)

Student's Address: _____ (No.) (Street) (City) (State) (Zip)

Father's Name: _____ E-Mail: _____

Father's Address: _____ Home Phone #: _____

Father's Work Phone #: _____ Cell Phone #: _____

Mother's Name: _____ E-Mail: _____

Mother's Address: _____ Home Phone #: _____

Mother's Work Phone #: _____ Cell Phone #: _____

Student's Physician: _____ Phone #: _____

Health Insurance Company: _____

Insurance Company Address: _____

Group # : _____ ID / Subscriber # : _____

Name of Cardholder: _____ Social Security Number of Cardholder: _____ - _____ - _____

Type Of Insurance: Private: _____ Group: _____

No Medical Insurance at this time: _____

Person to Notify In Case Of An Emergency And You Cannot Be Reached

(Other Than Those Listed Above)

Name: _____ Phone #: _____

Home Address: _____ Cell Phone #: _____

2009-2010

Health History **Student's Name:** _____

Drug Allergy (list) _____ **Food Allergy (list)** _____

Insect Bite Allergy (Life Threatening) _____ **Latex Allergy** _____ **Seasonal Allergy** _____

Epi-Pen required for Allergy? _____ **Other Medications used for Allergy** _____

Asthma _____ **Inhaler required?** _____ **How often used?** _____ **Nebulizer required?** _____

Other Medical Problem(s) _____

Current Medications: _____

_____ **Last Tetanus Shot:** _____

Details of Treatment / Activities to be Restricted (Requires Physician Note): _____

Medications / Parental Permissions

Permission for Over-the-Counter Medications

I give permission for authorized school personnel or the nurse employed by the school system to assist in the self-administration of each of the following medications that I have **initialed**:

(Parent / Guardian Signature)

MEDICATION

Tylenol	Mylanta	Vaseline
Ibuprofen	Artificial Tears	Baby Oil
Benadryl (Severe Reactions Only)	Baush & Lomb Eye Wash	Dry Skin Lotion
Sudafed*	Dramamine*	Immodium AD *

**THESE MEDICATIONS ARE FOR OVERNIGHT SCHOOL TRIPS ONLY!*

Permission for Prescription and All other Over-the-Counter Medications

Before administering **any prescribed or over-the-counter medication** not on the above approved list, the **School Clinic** must have on file:

- Completed Physician Form for Administration of Medication for **each medication (over-the-counter & prescribed medication)**. This form must be **completed** by your **Physician**.
- Each medication must be in the original, unopened container with the original label listing the ingredients.
- The student's name must be written on the container.

(The Physician Form for Administration of Medication can be obtained from the School Clinic and is good for one school year only).

Permission for Accompanying Physician

I give my permission for any physician who is present at band practices or events to provide first aid / medical treatment to my child if necessary.

(Parent / Guardian Signature)

Permission for Emergency Medical Treatment

I give permission for my child to be treated and/or transported by emergency personnel to the nearest health care facility at a cost assumed by parent. In the event of an emergency and I am (or other emergency contact is) unable to be reached, I give permission for emergency treatment in a hospital, including surgery requiring the use of an anesthetic.

(Parent /Guardian Signature)

ASTHMA ACTION PLAN

TO BE COMPLETED BY PARENT:

School Year _____

Student Information (Please print)

Student's Name: _____ Age: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Emergency Information: Include cell phone and beeper numbers.

Mother's Name: _____ Father's Name: _____

Name and address of parent/guardian: _____

Telephone (H): _____ Telephone (H): _____

Telephone (W): _____ Telephone (W): _____

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician Name: _____ Phone: _____

Preferred Local Emergency Department: _____

All Current Medications

Name of Medication	Dosage	Purpose	Time of Day

Does student use a Nebulizer at home? _____ YES _____ NO At school? _____ YES _____ NO

Triggers that may bring on an asthma episode: (mark all that apply)

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors or fumes
<input type="checkbox"/> Change in temperature	<input type="checkbox"/> Pollens
<input type="checkbox"/> Respiratory infection	<input type="checkbox"/> Molds
<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Cigarette smoke
<input type="checkbox"/> Allergic reactions, such as food or insects (describe):	
<input type="checkbox"/> Other (carpets, chalk dust, etc.):	

List any environmental measures, pre-medications or dietary restrictions needed to prevent an asthma episode: _____

*student is to notify his/her teacher, school nurse or designated official after each use of inhaler.

Notify Parent/Guardian in the following situations: _____

My signature delineates that my child has permission to possess and self-administer the asthma medication prescribed on the reverse side of this form. My signature, also, delineates that the school nurse has my permission to share information provided with the appropriate members of the educational team. This will be done on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider listed regarding any questions.

Parent's/Guardian's Signature: _____ Date: _____

PHYSICIAN ORDER FORM FOR AN ACUTE ASTHMA EPISODE

Student Name: _____

TO BE COMPLETED BY PHYSICIAN:

Signs and symptoms:

- ☐ Cough ☐ Shortness of Breath
☐ Bluish color skin/nails ☐ Unable to speak without taking a breath
☐ Tired, Wheezing ☐ Tightness in chest
☐ Anxious appearance or restlessness ☐ High pitched wheeze or unusual sound
☐ Other _____

Steps to take during an asthma episode

- 1. Never leave student alone – remain calm. Encourage student to relax.
2. Check peak flow (if available).
3. Assist student with prescribed medications (listed below). Student should respond to treatment in 15-20 minutes.
4. Observe and record student’s response to medication.
5. Observe student for adequate breathing.
6. Contact parent/guardian if _____

Seek Emergency Medical Help:

- ❖ No improvement 15-20 minutes after initial treatment with medication.
❖ Coughs constantly.
❖ Struggles for breath, hunches over, or sucks in chest and neck muscles in an attempt to breathe.
❖ Has difficulty in walking or talking i.e. can not speak in complete sentences.
❖ Blue or gray discoloration of the lips or fingernails.
❖ Has peak flow reading of _____.

Emergency Asthma Medications:

Name/Purpose of Medication _____ Dosage _____ Route _____
Diagnosis/Reason for which medication is given _____
If medication is to be given daily, at what time? _____ A.M./ _____ P.M. / _____ As Needed _____
If medication is to be given “when needed”, describe circumstances _____
Is refrigeration necessary? _____ YES _____ NO. If “as needed”, how often can it be repeated? _____
Possible side effects: _____ / Procedure to follow: _____
Length of time prescribed/discontinuation date: _____
Peak Flow Meter Order: _____ Green Zone _____ Yellow Zone _____ Red Zone _____

- ☐ This student suffers from asthma and has been instructed in self-administration of the prescribed inhaler. It is in my professional opinion that he/she should be allowed to carry and use his/her inhaler while at school.
☐ It is my professional opinion that the above student should not carry his/her inhaled medication.

* Authorization to carry the inhaler may be revoked if used inappropriately at any point during the school year.

Physician Signature (printed) _____ Date _____
Physician Signature (written) _____ Office Phone _____
Office Address _____ Fax _____

(School Staff Only) Completed Form Received On _____ BY _____

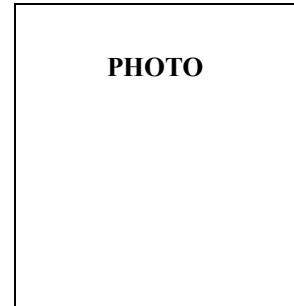
EMERGENCY FOOD ALLERGY AND SEVERE ALLERGY RESPONSE PLAN (AAP)

TO BE COMPLETED BY PARENT:

STUDENT INFORMATION (PLEASE PRINT)

Student Name: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____



EMERGENCY INFORMATION : INCLUDE CELL PHONE AND BEEPER #'S

Mother/Guardian Name: _____ Father/Guardian Name: _____

Telephone (H): _____ Telephone (H): _____

Telephone (W) : _____ Telephone (W): _____

Physician Name : _____ Telephone: _____

In the event a parent/guardian cannot be reached contact:

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE</u>
1.	_____	_____	_____
2.	_____	_____	_____

CHECK ANY SEVERE ALLERGY(IES) YOUR CHILD HAS:

- Insect Stings (List type) _____
- Food (List type) _____
- Pollens: Usual time reactions occur: ____ Spring, ____ Summer, ____ Winter, ____ Fall
- Dust
- Grass
- Animal (List type) _____
- Other (List) _____

CHECK SIGNS USUALLY PRESENT DURING AN ALLERGY ATTACK

- Difficulty Breathing
- Difficulty in Swallowing
- Loss of Consciousness
- Rash
- Nausea
- Swelling : How much? _____ Where ? _____
- Flushed or unusually pale skin
- Other (List) _____

Has hospitalization been needed in the past year for allergies ? _____ NO _____ YES (If YES) When? _____

Are medications needed for the allergy (ies) ? _____ NO _____ YES (List below)

******If medication is to be given at school the Physician Order Form and a Medication Order Form must be filled out.**

Notify Parent/Guardian in the following situations : _____

Any other information: _____

My signature allows permission to include my child's picture with this plan. I give permission for my child to administer, be administered or assisted in the self-administration of the Epi-Pen by authorized persons. This includes both in school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider who signs the Medication Order Form regarding any questions. The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the Epi-Pen.

Parent/Guardian Signature

Date

EMERGENCY FOOD ALLERGY AND SEVERE ALLERGY RESPONSE PLAN (AAP); 5/07.

PHYSICIAN ORDER FORM FOR AN ALLERGY ATTACK

Student Name: _____

ALLERGY(IES) TO : _____

Asthmatic: Yes No **High risk for severe reaction**

SIGNS OF AN ALLERGIC REACTION

<u>Systems:</u>	<u>Symptoms:</u>
• MOUTH	itching & swelling of the lips, tongue, or mouth.
• THROAT	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
• SKIN	hives, itchy rash, and/or swelling about the face or extremities .
• GUT	nausea, abdominal cramps, vomiting, and/or diarrhea.
• LUNG	shortness of breath, repetitive coughing, and/or wheezing.
• HEART	“thready” pulse, “passing-out”.

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

• **ACTION FOR PREVENTION:** {Please list allergens to avoid} _____

• **ACTION FOR MINOR REACTION:** _____

1. If symptom (s) is/are : _____, give _____
Medication/dose/route

Then call:

2. Mother _____ Father _____, or Emergency contacts.

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

• **ACTION FOR MAJOR REACTION;**

If ingestion is suspected and/or symptom(s) _____

Give _____ **IMMEDIATELY!**

It is my professional opinion that above named student be allowed to carry his/her own Epi-Pen __YES__ NO.

Then call:

1. Rescue Squad

2. Mother _____ Father _____, or Emergency contacts.

*****If medications are indicated, a Medication Form must be completed.

DO NOT HESITATE TO CALL RESCUE SQUAD!

**Physician Form For Administration of Medication (Nursing)
Or Assistance with Self Administration of Medication (School Staff)**

THIS FORM IS GOOD FOR ONE SCHOOL YEAR ONLY.

The following is to be completed by a health care provider (physician, nurse practitioner, dentist, etc). No medication of any kind will be given to your child until this information is completed and returned to the school. Remember, all medication must be in a **pharmacy-labeled container**. Over the counter medication prescribed by a health care provider must be brought to school in an unopened, labeled, original container. If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy/physician-labeled container and returned to the school. **Only one form for each medication is to be used.** Medication must be brought to school by a responsible adult. Please **do not send medication by elementary children.** A parent signature is required before a student can be assisted with the self-administration of medication or medication can be administered to the student.

TO BE COMPLETED BY PARENT:

Name of Student _____ Date of Birth _____ Allergies _____
 School _____ Grade _____ Teacher _____

I give permission for my child to be administered or assisted in the self-administration of the medication listed below by authorized persons. My child’s medical condition is stable and my child is competent to self administer this medication with assistance. This includes both at school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team. This will be done only on a “need to know” basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider listed below regarding any questions.

_____ Date _____ Parent/Guardian Signature _____ Home Phone _____ Work Phone _____ Emergency Contact Name/Phone _____

TO BE COMPLETED BY PHYSICIAN:

Name of Medication _____ Dosage _____ Route _____
 Diagnosis/reason for which medication is given _____
 If medication is to be given daily, at what time? _____ A.M. _____ P.M. _____
 If medication is to be given “when needed”, describe symptoms _____
 Is refrigeration necessary? Yes/ No. How soon can it be repeated? _____
 Possible side effects and procedure to follow _____
 Health Care Provider’s Name (**Please Print**) _____
 Health Care Provider’s Signature _____ Date _____
 Address _____ Telephone _____ Fax _____

(School Staff Only) Completed Form Received On _____ By _____