

**NORTHEAST METRO TECH HIGH SCHOOL HEALTH OFFICE  
781-246-0810, EXT 1624/1620 – FAX (781)246-9323**

**IMPORTANT  
PARENT PACKET**

**THIS PACKET MUST BE RETURNED TO:**

**NORTHEAST METRO TECH HEALTH OFFICE  
100 HEMLOCK ROAD  
WAKEFIELD, MA 01880**

# NORTHEAST METRO TECH HIGH SCHOOL HEALTH OFFICE

(781) 246-0810, EXT. 1624/1620 - FAX (781) 246-9323

## RETURN IMMEDIATELY TO SCHOOL NURSE STUDENT HEALTH INFORMATION

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Is student allergic to any foods, medication, insects, etc? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If so please be specific.

Treatment Plan: Epipen Required? \_\_\_\_\_

Please **CIRCLE** all that apply to this student:

**ADD-ADHD - ASTHMA - DEPRESSION - DIABETES - HEART CONDITION- MIGRAINES**

**OTHER:** \_\_\_\_\_

3. Is this student taking any medication on a regular basis? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please specify name of medication and reason. \_\_\_\_\_

**IF MEDICATION IS TO BE ADMINISTERED DURING SCHOOL HOURS, PLEASE CONTACT THE NURSE AT EXTENSION(S) 1624/1620**

4. Does this student have any physical condition that requires him/her to be medically excused from physical education /pool? **A DOCTOR'S NOTE IS REQUIRED FOR EACH SCHOOL YEAR.**

Yes/Explain:

5. Please **CIRCLE** all that applies: **Glasses - Contact Lenses - Hearing Aid - Orthopedic Brace / Support**

Physician Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Other medical contacts: Therapist, Psychiatrist, etc.

Name: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Please add further information regarding any physical or emotional needs that you feel necessary to facilitate the health and well being of this student at Northeast Metro Tech.

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 care physician for purpose of referral, diagnosis and treatment.

\_\_\_\_\_  
**Parent/Guardian Signature**

Nurse/studenthealth-infosheet2010-2011

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

# NORTHEAST METRO TECH HIGH SCHOOL HEALTH OFFICE

## MEDICATION PERMISSION FORM

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

**Allergies:** \_\_\_\_\_

I give permission to the school nurse to administer the following medications to my child according to established protocols. All other medications, including inhalers, require a written order from a licensed prescriber (physician, dentist, nurse practitioner) and written parental permission. Medication is to be sent to school in the original container. Your pharmacy can give you a duplicate container for school.

### PLEASE!!!

CROSS OUT ANY PRODUCTS YOU DO NOT WANT YOUR CHILD TO RECEIVE.

Acetaminophen  
(Tylenol)

Acetaminophen 325 mg 1- 2 tablets every four hours as needed for pain, injury or fever.

Ibuprofen

Ibuprofen 200 mg 1-2 tablets every six hours as needed for pain, injury, or fever.

Bacitracin Ointment

Bacitracin ointment as needed for cuts scrapes, etc. 1-3 times daily.

Calagel

As needed to relieve skin itch/irritation from poison ivy, sumac, oak or insect bites.

Orajel

Orajel as needed to affected area for tooth pain or mouth irritations four times per day.

Antacids

Antacid tabs 1-2 as needed for upset stomach, heartburn or sour stomach. Not to exceed 6 tabs per day.

Cough Drops

1-2 drops as needed for cough or throat irritation.

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**Parent/Guardian Signature**

**Date**

**(OVER)**

Nurse/medpermission

COMPLETE ONLY IF YOUR CHILD HAS ASTHMA

ASTHMA CARE PLAN

My child \_\_\_\_\_ has a history of asthma frequently

brought on by \_\_\_\_\_

\_\_\_\_\_ My child does not require the use of an inhaler.

\_\_\_\_\_ My child requires the use of the following inhaler:

#1. \_\_\_\_\_

#2. \_\_\_\_\_

#3. \_\_\_\_\_

Under Massachusetts regulations for the dispensation of prescription medications students may keep an inhaler with them if the following conditions are met:

1. Written permission is on file from a parent/guardian.
2. The student understands proper technique and the circumstances that require him/her to use a inhaler.
3. **THE INHALER IS PROPERLY LABELED WITH THE CHILD'S NAME AND THE PRESCRIPTION LABEL ATTACHED.**

In accordance with these guidelines I give my child permission to use the following inhaler(s) as specified:

Inhaler #1. \_\_\_\_\_

Inhaler#2. \_\_\_\_\_

\_\_\_\_\_ My child will keep these inhalers with him/her.

\_\_\_\_\_ I will provide an inhaler(s) to be kept in the office.

\_\_\_\_\_ I do not feel at this time that it is necessary for my child to have an inhaler available at school but should circumstances change I will send in an inhaler with a written note of permission.

The American Asthma Association recommends the use of a peak flow meter before using an inhaler.

\_\_\_\_\_ My child uses a peak flow meter. The usual reading is \_\_\_\_\_

\_\_\_\_\_ My child does not use a peak flow meter.

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Signature: \_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_ Date

Nurse/AsthmaCarePlan-