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 **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.

_____

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.

Signature: _____ _____
Parent/Guardian Date

Nurse/AsthmaCarePlan-