Equipping · Engaging · Encouraging

St. John's Lutheran School

Health and Medication Form

2024-2025

Student Name: _____ Grade: _____

No School personnel shall administer any prescription or non-prescription medication unless the school has the student's current and complete Health and Medication Form on file. All prescription medication must have doctor's orders included. If doctor's orders are not included, orders may be faxed from the doctor's office. **Allergy plans must be updated each school year.**

A Health and Medication Form is distributed for each student at registration. The Health and Medication Form is also available in the school office and on our website.

1. Does your child have any food allergies? If yes, please note allergy and treatment:

   _____

   _____

   1. Yes _____ No _____

2. Is your child allergic to insect stings? If yes, please note reaction and treatment:

   _____

   _____

   2. Yes _____ No _____

3. Does your child have asthma? If yes, please note medication and restrictions, if any:

   _____

   _____

   3. Yes _____ No _____

4. Is your child on any medications? If yes, please specify:

   _____

   _____

   4. Yes _____ No _____

5. Does your child need medication in school? If yes, please complete the Medication Permission section. (see reverse side)

   5. Yes _____ No _____

6. Does your child have any health concerns of which the school should be made aware? If yes, please explain:

   _____

   _____

   6. Yes _____ No _____

MEDICATION PERMISSION

_____ _____

Medication/Treatment Time(s) to be administered

May student self-administer medication? Yes _____ No _____

Please check all that apply:

ASTHMA_____ EPI-PEN AUTO INJECTOR_____ DIABETES_____

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.
Yes _____ No _____

I also request that this student be allowed to carry the above-described medication on their person during school hours and school related activities in order to facilitate the self-administration of the medication as needed. Yes _____ No _____

IBUPROFEN OR ACETAMINOPHEN CONSENT

I do not give my permission, please call first_____

I give my child permission to be given:

_____(1, 2, or 3—please circle dosage) jr strength (**age 2-11**) generic **ibuprofen** chewable tablets every 6 hours according to dosage instructions on label.

_____(3, 4, or 5 please circle dosage) jr strength (**age 2-11**) generic **acetaminophen** chewable tablets every 4 hours according to dosage instruction on label

_____ I understand children 12 and older will not receive chewable tablets unless brought from home

_____(1 or 2) **200 mg** adult strength tablets of generic **ibuprofen** every 6 hours

_____(1 or 2) **325 mg** adult strength tablets of generic **acetaminophen** every 4 hours

Parent Name: _____

Parent Signature: _____

Date: _____