ARCHBISHOP ALTER HIGH SCHOOL
OTC MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____ Male ___ Female ___ Grade _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian #1 Name_____ Phone #_____

Parent/Guardian #2 Name_____ Phone #_____

Emergency Contacts: Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

MEDICATIONS

Archbishop Alter High School has my permission to administer the following over-the-counter medications. Medications will be administered according to package directions for age/weight.

Medication	YES	NO
Acetaminophen (Tylenol) - As directed on label for fever or pain	☐	☐
Ibuprofen (Advil or Motrin) - As directed on label for fever or pain	☐	☐
Claritin As directed on label for seasonal allergies	☐	☐
Antacid (Tums) As directed on label for upset stomach and/or heartburn	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
Diphenhydramine (Benadryl) As directed on label **FOR ALLERGIC REACTIONS ONLY with a PCP/Provider Order**	☐	☐
Cough Drop(s)	☐	☐

First aid treatments (check the ones that you consent to your child receiving if needed):

☐ Hydrogen peroxide ☐ Hydrocortisone cream 1% ☐ Burn Cream/Aloe
☐ Triple antibiotic ointment ☐ Benadryl cream ☐ Allergy eye drops
☐ Wound cleanser/Bactine ☐ Calamine lotion ☐ Muscle rub

Parent/Guardian Signature: _____ Date:_____
PCP/Provider Signature: _____ Date:_____

ARCHBISHOP ALTER HIGH SCHOOL
MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____

MEDICAL HISTORY

Has your child ever been diagnosed or treated for any of the following?			If Yes, please explain. Is this a current issue? Does your child see a doctor for this condition?
Diabetes** Type 1☐ Type 2☐	YES	NO	
Thyroid Disease	YES	NO	
Asthma**	YES	NO	Inhaler: ☐ ☐ ☐
Heart or Cardiovascular Conditions	YES	NO	
Stomach Disorders	YES	NO	Acid reflux___ Heart burn___ Ulcers___ Other_____
Intestinal Disorders	YES	NO	Chronic constipation___ IBS___ Other_____
Headaches	YES	NO	
Migraines	YES	NO	
Seizures**	YES	NO	Type:_____ Date of last seizure:_____ Currently under Doctor's care due to seizures: Yes___ No___
Kidney Disease	YES	NO	
Depression	YES	NO	
Anxiety and/or Panic attacks	YES	NO	
Mental Health Diagnosis	YES	NO	
ADD/ADHD	YES	NO	
Autism	YES	NO	
Vision problem/condition	YES	NO	Wears glasses___ Wears contacts___
Hearing problem/condition	YES	NO	Tubes___ Other:
Neuromuscular Disorder	YES	NO	
Cancer	YES	NO	
Genetic Disorder	YES	NO	
Other medical condition(s):	YES	NO	

****Diabetes, Asthma, Seizures, and Anaphylactic allergies must have emergency action plans from their doctor on file, forms at www.alterhs.org upper R open-PARENTS scroll down to clinic for forms.**

ALLERGIES

☐ YES (provide details below) ☐ No Known Allergies

Allergen	Specify Name/Type	Reaction	Treatment
Food			
Medication			
Stinging Insect			
Environmental			
Animal			

CURRENT HOME MEDICATIONS/VITAMINS			
MEDICATION	**REASON FOR TAKING**	**DOSAGE**	**HOW OFTEN/TIME**

PRESCRIBED MEDICATIONS TO BE GIVEN AT SCHOOL (*CONSENT FORM MUST BE SIGNED)			
MEDICATION	**REASON FOR TAKING**	**DOSAGE**	**HOW OFTEN/TIME**

***CONSENT FORMS MUST ALSO BE SIGNED FOR SELF CARRY MEDICATIONS (EPI PENS, INHALERS)**

INSURANCE

Is your child covered by Health Insurance? YES NO HMO/Managed Care YES NO
Is your child enrolled in the Medicaid Program? YES NO UNSURE

Last physical exam Healthcare Provider
Last dental exam Dental Provider
Last vision exam Vision Specialist
PCP/Provider
Name
Address:
Phone #

****Emergency action plans, self carry medication forms, and medication consent forms can be found on the school website. www.alterhs.org Upper Right open PARENTS, scroll down to Clinic for forms. Forms must be completed by PCP/Provider and signed by Parents.**

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School Nurse

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www.alterhs.org

ARCHBISHOP ALTER HIGH SCHOOL