

Student's Name: \_\_\_\_\_ Science Teacher: \_\_\_\_\_ Period: \_\_\_\_\_

**Due: March 13, 2009**

**Medical Information**

Please provide us with the following information:

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Is your child covered by a health or accident policy? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, name of carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Group # \_\_\_\_\_

Date of last Tetanus (DPT) shot \_\_\_\_\_

Does your child have allergies (medications, food, latex, insect bites)? \_\_\_\_\_

As mandated by state law, the school nurse who accompanies our students to Fairview Lake Camp is **unable** to administer **over-the-counter medication** to your child unless we have a **physician's signature** for each medication your child may require.

**PLEASE NOTE: this letter only pertains to over-the-counter medications.** If your child is on prescription medication or is asthmatic and uses an inhaler or nebulizer, we need a doctor's written instructions on administering the medication or using the inhaler/nebulizer. A label on the prescription is not sufficient.

**Option One:** I do not want my child given any **over-the-counter medication**.

Parent's/Guardian's Signature \_\_\_\_\_

Parent's/Guardian's Name (Please Print) \_\_\_\_\_

**Option Two:** I would like these **over-the-counter medications** to be available to my child from the nurse on duty at Fairview (**requires both parent and physician signatures**).

**SCHOOL NURSE WILL PROVIDE**

**PARENTS MUST PROVIDE**

- \_\_\_ Tylenol 325mg Regular Strength
- \_\_\_ Tylenol Junior Strength Chewable 160mg
- \_\_\_ Advil or Ibuprofen 200mg Tablets
- \_\_\_ Motrin Junior Strength Chewable 100mg
- \_\_\_ Benadryl Caplets 25mg
- \_\_\_ Benadryl Children's Liquid
- \_\_\_ Tums

- \_\_\_ Zyrtec
- \_\_\_ Claritin
- \_\_\_ Nasal Spray (Specify)
- \_\_\_ Eye Drops (Specify)
- \_\_\_ Cough Syrup (specify)
- \_\_\_ Other (Specify)

Please have your physician place a check (✓) next to the medications your child can be given and have him/her sign this letter. Package directions will be followed unless otherwise directed.

My child \_\_\_\_\_ can be given the above checked over-the-counter medications.

Parent's/Guardian's Signature \_\_\_\_\_

Parent's/Guardian's Name (Please Print) \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_

Physician's Signature \_\_\_\_\_

**Helpful Hint:** Drop off this form and a self-addressed, stamped envelope to your physician at your earliest convenience. This will allow your physician to fill out and return the form before the **due date, March 13, 2009**. It can also be faxed to the Hammarskjold Health Office at 732-651-8073.