Hill View Montessori Student Health Form

Student Name: _____

Date of Birth: _____ Grade: _____

Medical treatment

In the event of an emergency, HVM will make every effort to contact the parent/guardian. In the event that we are unable to reach the parent/guardian, your son/daughter will be transported by ambulance to the nearest medical care facility and/or to the _____ hospital.

(Specify *the preferred hospital)*

Physician Name: _____ Phone Number: _____

Dentist Name: _____ Phone Number: _____

Please check all that apply to your child:

☐ Diabetes ☐ Asthma ☐ ADD/ADHD ☐ Seizure Disorder ☐ Other: _____

☐ Hospitalizations/Surgeries: _____

☐ Allergies (food, insects, medicines, environment):

_____

_____

_____

My son/daughter currently receives the following medications **AT HOME:**

Name: _____Dose: _____Frequency: _____Why? / Diagnosis: _____

Name: _____Dose: _____Frequency: _____Why? / Diagnosis: _____

Name: _____Dose: _____Frequency: _____Why? / Diagnosis: _____

Name: _____Dose: _____Frequency: _____Why? / Diagnosis: _____

If your son/daughter needs to have medication administered **at school,** you should contact the school nurse to have the proper plans in place, ONLY the school nurse may administer medication to your son/daughter.

Permission to Administer Over-the-Counter Medications

I give the school nurse permission to administer the following over-the-counter medications in accordance with established protocols. (*Check all that apply*)

☐ Ibuprofen/Motrin, Advil ☐ Acetaminophen/Tylenol ☐ Tums ☐ Benadryl

HIPAA/FERPA Notice Information

I give permission for the school nurse to share information relevant to my son/daughter's health condition and medication with the appropriate HVM personnel or contracted person who comes into contact with my son/daughter, to meet the needs of health and safety of my son/daughter.

Parent/Guardian Signature: _____ Date: _____

(Expires *at the end of the current school year)*

Daytime Phone Number: _____

Reviewed August 2023