# Cambridge Friends School

## Additional Medical Information Form 2008-2009

To be filled out and signed by student's parent or guardian

Student Name________________________________ Date of Birth____________________________

I grant permission to the school to provide necessary medical attention in an emergency. I understand that efforts will be made by the school to contact me and my child's physician when further medical attention seems advisable. I understand that the school is not responsible for sickness or accidents resulting in any way from school activities, including athletics and trips.

Parent or Guardian's Signature_________________________________ Date_____________

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**The following information is in addition to that which your child's doctor is providing.**

Have you or your pediatrician checked your child for head lice recently? Yes ❒ No ❒

**If not, please check your child for head lice before the first day of school.**

For Girls Has she menstruated?________ If not, has she been told about it?_________________

Is her menstrual history normal?_________________________________________________________

Has your child had chicken pox? Yes ❒ No ❒ Date____________________

Does your child have health, emotional, or developmental issues to which the school should be alerted? If so, please describe.

Does your child have any allergies? Yes ❒ No ❒ If yes, please describe **symptoms** and treatment.

Has your child needed an EpiPen or Benadryl for this allergy? Yes ❒ No ❒ Has your child needed the emergency room for this allergy? Yes ❒ No ❒

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**Please note:** The Massachusetts Department of Public Health has made changes in laws regarding prescription medication administration in school. If possible, have your doctor prescribe the medicine for other than school hours. If your child does need to receive medication during school, we'll need written consents. Forms and explanation are included in this mailing.

**—Over—**

**Does your child have prescription medications that must be kept or administered at school?** (e.g., asthma medication, EpiPen, medications for attention or behavior) ☐ No ☐ Yes If yes, please return the blue and salmon colored forms included with this mailing. The school must have these on file to administer prescription medications.

If your child has asthma or life-threatening allergies, please file an ASTHMA or ALLERGY ACTION PLAN with the school nurse. If you need a copy, ask at her office, get one from your child's pediatrician, or download one from the Internet.

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Please fill in the form below to give your permission for non-prescription medications to be given to your child. If you choose not to fill out this part of the form, the nurse, or someone working under her supervision, will call you if and when your child requires one of these over-the-counter medications.

I give permission to the school nurse or school personnel working in consultation with the school nurse to give my child

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First Name Last Name

☐ Tylenol (Acetominophen) for headache, pain, or fever

☐ Advil (Ibuprofen) for musculoskeletal pain, menstrual cramps, headache, or fever

☐ Midol (a combination of Tylenol and a diuretic for menstrual cramps)

☐ Tums (a gas relief medication) ☐ Sunscreen

☐ Sudafed (for colds, runny noses, or nasal congestion)

☐ Benadryl (diphenhydramine hydrochloride) for allergic reactions, hives, or a rash

☐ Other non-prescription medications (for example: cold, cough, allergy, or other over-the-counter preparations listed here:

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Signature of Parent or Guardian Please Print Your Name

______________________________________________

Home Phone # Work Phone #

______________________

Date