

# Somerset Berkley Regional High School

## Student Medical Treatment Form - Annual Update (Please Print)

Parents: To ensure accurate response in the event of a medical issue, please complete all fields listed below.

Student's Name: \_\_\_\_\_  
Last First Middle

Grade: \_\_\_\_\_ Birth Date: (MM/DD/YYYY): \_\_\_\_\_

### **MEDICAL INFORMATION**

Physician Name: \_\_\_\_\_ Tel #: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Tel #: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_

☐ Public Insurance ☐ Private Insurance ☐ Mass Health ☐ No Insurance

Allergies: \_\_\_\_\_

Current Health Problems: \_\_\_\_\_  
\_\_\_\_\_

Current Medication: \_\_\_\_\_  
Name Date Time of Dose

Current Medication: \_\_\_\_\_  
Name Date Time of Dose

### **PERMISSION FOR OVER THE COUNTER MEDICATIONS**

My child has permission to receive non-aspirin medications at the discretion of the school nurse and the standing orders authorized by the Somerset Berkley Regional High School District physician: ☐ YES ☐ NO

### **PERMISSION FOR TREATMENT TO INJURED EXTREMITIES**

I hereby authorize the school nurse to apply a splint, sling, or elastic wrap to an injured extremity (e.g., arms, legs, feet, fingers) as deemed necessary: ☐ YES ☐ NO

### **PERMISSION FOR EMERGENCY TREATMENT**

In the event of a serious illness/injury, I hereby authorize the school to contact my child's physician and/or to seek emergency medical care including transportation to a medical facility. I hereby authorize the physician and emergency room staff to administer care that is deemed necessary. I understand that every effort will be made to contact the family and emergency contacts first: ☐ YES ☐ NO

### **RELEASE OF INFORMATION**

I give permission to share the above information with appropriate school staff and employees: ☐ YES ☐ NO

I authorize the school nurse to contact the above physician(s) and or therapist (s), when appropriate, for a 2-way exchange of medical information. ☐ YES ☐ NO

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship \_\_\_\_\_

## **SOMERSET BERKLEY REGIONAL HIGH SCHOOL STANDING ORDERS**

By checking "Yes" on the reverse side of this treatment form, you are authorizing the school nurse to give your child any of the following over-the-counter medications and treatments:

### **ORAL/INHALANT**

- Tylenol 500mg. 1-2 tablets every 4-6 hours as needed
- Ibuprofen 200mg. 1-2 tablets every 6-8 hours as needed
- Tums (antacid) 2-4 tablets as needed
- Cough drops (generic - cherry, lemon, menthol) as needed
- Ammonia inhalant as needed

### **TOPICAL/EYE CARE**

- A & D ointment/Vaseline/Aquaphor/Eucerin
- Bacitracin ointment
- Bactine Spray
- Benadryl ointment/spray
- Burn gel/spray/Aloe
- Caladryl
- Eye wash/contact eye solution/Visine/Refresh
- Hydrogen peroxide
- Sting relief

*Note:* The school nurse has permission to substitute and over-the-counter/topical/eye care medications due to availability of products.

### **TREATMENT TO INJURIES**

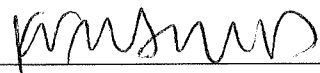
- Application of splint, sling or elastic wrap to injured extremity (arms, legs, feet, fingers)
- Application of steri-strips and/or butterfly bandages to lacerations

### **EMERGENCY TREATMENT**

- Anaphylactic Emergency
  - EPI-PEN: Epinephrine Auto-Injector 0.3mg/Adult unit dose, IM, as needed for emergency treatment of anaphylaxis (severe allergic reaction)
  - Benadryl: 25mg tablets by mouth
  - Opioid Overdose: Nasal Naloxone (Narcan) 4mg intranasal spray

### **DISTRICT PHYSICIAN AUTHORIZATION**

I hereby authorize the Somerset Berkley Regional High School Nurse to administer the above treatments as deemed necessary.

Physician Signature: 

Date: 7/1/2023

Print name: Katherine Frias MD

ID #: \_\_\_\_\_