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 #: _____