HEAL	LTH INFORMATION (please answer all questions)					SCHOOL YEAR:		
Name:	(Last)	(First)	(MI)	_ □ M □ F	Date of Birth: _	Grade:	Bus Rider: □YES□NO	
What r <b>Medic</b>	medication(s) is ation given at:	your child currentl  ☐ <b>Home (Only)</b>	y taking? On On	ly) 🗆 Hom	e & School	Only in an Emergen	cy	
	awareness and		n during the scho	<mark>ool day, you <u>N</u></mark>	<b>IUST</b> contact the se	ulin, etc.) or allergy the chool nurse to discuss a		
ΙΙ	THIS MUST BE DONE EACH SCHOOL YEAR							
ad.	Written permission must be received from the parent/guardian prior to medication administration. Licensed school nurses will supervise administration of medications. All medications will be given according to label instructions and in accordance with OTC school district policy.  Listed below are the over-the-counter medications that our school keeps in stock for administration to students:  Acetaminophen/ibuprofen (regular strength). WILL NOT BE GIVEN BEFORE 10:00am OR AFTER 2:00pm							
	***(may l rest, etc.)  Antacid (' Caladryl Oral Pain Diphenhy Antibiotic Basic 1st A	be given for fever ov as deemed necessar WILL NOT BE GIV Reliever (Ora-jel) dramine (given in c c ointment Aid Supplies (such a	er 102 degrees, a y and appropriate VEN BEFORE 10 ase of allergic rea s, but not limited	nd headaches by licensed to common or Al ction) to, bactine, p	or other pains not nurse, TER 2:00pm	relieved by other mear	as such as ice, heat, food, fluids,	
sig	nature. <u>If there</u> :	are any OTC stock i	meds that your ch	ild should N	OT receive, contact	the school nurse.	urse, please indicate with your	
the ele M	e ability of a stu ements of health edicaid, the dist	dent to succeed in that would advers rict will seek reimb	school. The inter ely affect the stu- oursement for vis	nt of the exandent's ability ion and hear	ns or screenings is to achieve to his/ling screenings. By	to detect defects in he her full potential. Show	e these health factors play in earing, vision, or other ald a student have Arkansas consent grants the school qualifying students.	
	o you currently l edicaid #:	have Arkansas Med	<mark>licaid?</mark> Yes	No				
Do	o you give conse	ent for Cabot Schoo	ol District to bill	Medicaid fo	r reimbursement o	of mandated screening	s? 🗆 YES 🗆 NO	
Pa	rent/Guardian S	signature:				Date:		
		Cabot School District tions in accordance v		ctors, and Sch	ool Employees shall	be immune from civil li	ability for damages resulting from the	
may be that in t	released to appro the event of an em	priate School Distric	t employees and er reat and transport r	nergency person ny child to the	onnel in order to pro nearest hospital. Th	vide for the health and s	derstand that the above information afety of my child. I also understand al staff have my authorization to	
							permission for my child to onsent forms will be provided	
for my	consideration pr	rior to the clinic.	$\square$ YES $\square$ N	<b>10</b>				
Signati	ure of Parent/Gua	rdian:				Date:		