Scituate Public Schools
Annual Student Health and Medication Consent Form

Your Child's Full Name: _____ Date of Birth:___/___/_____ Grade:____

Please complete the following information for use by the school nurse.

1) Please list any health concerns or issues that the school nurse should be aware of:

_____

_____

2) My child is known to have the following allergies:

_____

3) My child is currently taking the following medication(s) at home (to be completed if not in violation of confidentiality). You must submit an additional consent form for the administration of prescription medication to be administered at school. (https://scit.org/page/62/health-services)

_____

_____

Parent/Guardian Medical Consents	
x____ **Initial Here**	I have initialed to give permission to Scituate school nursing staff to exchange information with my child's physician for the purpose of referral, diagnosis, and treatment in the school setting, OR with Emergency Medical Services in the event your child needs to be transported to the nearest medical facility. Student's Physician: _____ Physician Phone: _____ Student's Dentist: _____ Dentist Phone _____

Please check off any or all the following medications that you give permission for the School Nurse to provide to your child in accordance with the standing doctor's order for the Scituate Public Schools as prescribed by Dr. Katie McBrine, School Physician.

Please Check All That Apply

□ **Purified water eye wash**	□ **Anti-Itch Lotion**	□ **Ibuprofen (ex. Advil)**
□ **Diphenhydramine (ex. Benadryl)**	□ **Throat Lozenge**	□ **Petroleum Jelly (ex. Vaseline)**
□ **Antibiotic Ointment**	□ **Acetaminophen (ex. Tylenol)**	□ **Contact Lens Solution**

***Please contact your school nurse if you would like the complete ingredient label of any item listed above.**

x____ **Initial Here**	Sunscreen: I have initialed to permit my child to self-apply mineral-based, non-aerosol sunscreen when provided by the district ***only during special events with potential sun exposure of > 80 minutes.*** (i.e., field days/field trips)
x____ **Initial Here**	I have initialed to give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.

Please remember to initial the sections above to indicate your consent.

Signature of Parent/Guardian: X_____ **Date** ____/____/_____

Please return this form to your school nurse as soon as possible