salem SA academy
CHARTER SCHOOL

45 Congress Street ▪ Salem, MA 01970 ▪ 978.744.2105 ▪ www.salemacademycs.org

Salem Academy Charter School
2021 - 2022 School Year
Student Health Information

Student Name: ____
LAST FIRST MIDDLE

Student Date of Birth: __________

Student Grade Level: ____ 6th ____ 7th ____ 8th ____ 9th ____ 10th ____ 11th ____12th

Student Home Address: ____

Parent or Guardian #1: _______________________ **Home Phone**: ( ) _______________________
Cell phone: ( ) ____________________________ **Work phone**: ( ) ________________________

Parent or Guardian #2: _______________________ **Home Phone**: ( ) _______________________
Cell phone: ( ) ____________________________ **Work phone**: ( ) ________________________

Would you like to be emailed regarding **Non-Emergency Questions or Concerns** (e.g. medication refills, health form status, etc.)?

- ▢ Yes, please email me regarding non-emergency matters
  Preferred Email Address: ___________________________
- ▢ No, I would always prefer to be called

Emergency Contacts that are authorized to assume responsibility for your child in an emergency if the school is unable to contact Parents/Guardians immediately:

1. Name _______________________ Relationship ________________ Phone: ________________
2. Name _______________________ Relationship ________________ Phone: ________________

Family Doctor/Primary Care Practitioner: ________________________ **Number**: ( ) _____________
Family Dentist: ___________________________ **Number**: ( ) __________________
Health Insurance Provider: ________________________ **Health Insurance Policy #**: _________________
Preferred Hospital: ______________________________

Authorization to Receive/Release Information

By selecting below, I, the parent/legal guardian of my child, authorize the release of information as follows. I understand that the exchange of information may occur verbally and/or in writing, including, but not limited to, sharing/receiving pertinent health information with appropriate health care providers.

- ▢ I authorize Salem Academy Charter School to **RECEIVE** information concerning my child from my child's Family Doctor/Primary Care Practitioner/Specialist, etc.
- ▢ I authorize Salem Academy Charter School to **RELEASE** information concerning my child to my child's Family Doctor/Primary Care Practitioner/Specialist, etc.

___________________________ ____________________________ ____________
Parent/Guardian Name Parent/Guardian Signature Date

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Student Medical and Emergency Information

Student Name: ________________________ _____________Date of Birth: ___________

✓ **Does your child have any allergies?** If Yes, please specify what type of allergies below:

- ▢ Yes
- ▢ No

Foods (Nuts, Dairy, Fish, etc.): ____________________
Environmental Allergens (Bees/insects, Animals, etc.): ____________________
Medications: ____________________

✓ **Does your child have any Epi-Pen?**

- ▢ Yes
- ▢ No

✓ **Does your child see an Allergist for this allergy?**

Allergist Name: _______________________ Phone Number: _________________________

✓ **Does your child have any of the following Medical Conditions?**

- ▢ Asthma
  - ▢ Inhaler used
- ▢ Diabetes
- ▢ Attention Deficit Hyperactivity Disorder (ADHD)
- ▢ Headaches/Migraines
- ▢ Seizures
- ▢ Heart Conditions
- ▢ Sickle Cell Disorder
- ▢ Mental health concerns
- ▢ Constipation or Urinary Tract Infections (UTIs)
- ▢ Celiac Disease
- ▢ Food Intolerances
- ▢ Vision or Hearing Issues
  - ▢ Glasses/Contact lenses used
  - ▢ Hearing Aid used

✓ **Are there any other medical conditions/concerns that we should be aware? Is there anything else you think we should know about your child?**

____

____

✓ **Does your child take Medication on a daily basis? If yes, please specify below:**

- ▢ Yes _______________________

✓ **Would these medications need to be administered at school? If yes, please specify below**:

- ▢ Yes _______________________

Please be aware that there may be times when it will be necessary to share some of this information with school administrators, teachers, or other members of the school faculty and staff. If there is any reason you would not want this information shared, please contact the school. In case of a medical or psychiatric emergency and I cannot be reached, I give permission to Salem Academy Charter School to render treatment to the above named student. I give permission for transport via ambulance in case of such an event.

___________________________	___________________________	____________
Parent/Guardian Name	Parent/Guardian Signature	Date

Revised May 2021

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Salem Academy Charter School
2021-2022 School Year
Permission to Treat

Student Name: ___________________ Student Grade Level: ________ Date of Birth: _______

All Students must have signed Permission to Treat forms completed *every school year*. This form allows the School Nurse to provide a number of over-the-counter remedies on an as needed basis, and is reviewed annually by the school's Medical Director.

Any other medication not listed below will require a Written Order from a Licensed Prescriber (physician, dentist, nurse practitioner) and written parental permission. All medications MUST be kept in the nurse's office, unless it has been determined that a student has Permission to Carry the medication on their person.

Please **Select all Medications** that you wish your child to receive while at school:

- ▢ **Tylenol (Acetaminophen)** Children ages 5-11 years will be given a dose according to their weight* Children 12 years and older may receive 1-2 tablets (325-650mg) every 4 hours as needed for pain relief
- ▢ **Advil (Ibuprofen)** 1-2 tablets (200-400mg) every 4-6 hours as needed for pain relief
- ▢ **Benadryl (Diphenhydramine)** 1-2 tablets (25mg-50mg) every 4-6 hours as needed for hypersensitivity reactions
- ▢ **Cough Drops** 1 cough drop every 2 hours as needed for relief of cough or sore throat
- ▢ **Bacitracin Ointment** 1 – 3 times a day as needed for cuts, scrapes, etc.
- ▢ **Calamine Lotion** As needed to relieve itching from poison ivy, poison sumac, poison oak.
- ▢ **Hydrocortisone Cream** As needed 3 times daily to relieve itching associated with minor skin irritations.
- ▢ **Orajel (Benzocaine)** As needed for toothache pain.
- ▢ **Tums antacid tablet** Relief of acid indigestion, sour stomach, and upset stomach, no more than 6 tablets per day.
- ▢ **Pramoxine HCL (sting relief)** As needed for the temporary relief of insect bites, hives, and rashes.

By selecting the listed Medications/Remedies above, I give permission to the School Nurse to administer the following medications to my child according to established protocols.

To the best of my knowledge, my child has **no allergy or sensitivity** to any of the above named products.

I give permission to the school nurse to share with appropriate school personnel information relative to any described health concerns. I give permission for the school nurse to share pertinent medical information with appropriate health care providers.

Parent/Guardian Signature: ____________________________________ Date: _______________________

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