Jefferson C-123
Yearly Health Assessment
for Returning Students

Student's Name:_____ Today's Date: _____

Insurance Type: (Required information. Please circle appropriate response)

☐ Private ☐ MC+ ☐ Medicaid ☐ None

The following are standing order medications and treatments that may be administered to your child at school with your permission only. This form is valid for the current school year and gives permission for treatment by the school nurse or one of the trained health designees.

Please put an (X) beside each medication/treatment that your child has permission to receive:

☐ Ibuprofen 200-400 mg (minor pain, headache, fever, cramps, injuries)
☐ Tylenol 325-650 mg (minor pain, headache, fever, cramps)
☐ Caladryl Lotion (minor itching)
☐ Hydrocortisone Cream (minor itching)
☐ Benadryl 12.5 - 25 mg tablet or liquid (mild allergic reactions)
☐ Triple Antibiotic Ointment (applied to minor cuts and abrasions)
☐ Peroxide (used to clean minor cuts and abrasions)
☐ Sterile Saline Eyewash (minor eye irritation)
☐ Blistex or Vaseline (dry, chapped lips)
☐ Orasol gel or Anbesol (cold sores, fever blisters, toothache)
☐ Aloe Vera spray/gel or Solarcaine (minor sunburns or burns)
☐ Tums (minor abdominal discomfort, indigestion)
☐ Peppermint (nausea, sore throat, cough)
☐ Throat Lozenge/Fruit Breezer (minor cough, throat irritation)

Does your child have any of the following conditions? (Please indicate)

☐ ADD ☐ Allergy ☐ Arthritis ☐ Asthma ☐ Deafness ☐ Depression
☐ Diabetes ☐ Heart Irregularity ☐ Kidney Disorder ☐ Seizure Disorder ☐ Other

If marked Allergy or Other, please describe:_____

******(*If any of the above are checked, please see school nurse upon registration of student*)******

Medications taken on a regular basis (including inhalers):

Name:_____Dosage:_____ Reason:_____ Home only ☐ @ School ☐

Name:_____Dosage:_____ Reason:_____ Home only ☐ @ School ☐

Name:_____Dosage:_____ Reason:_____ Home only ☐ @ School ☐

Family Doctor: _____

Family Dentist:_____

Parent/Guardian Signature:_____ Date_____