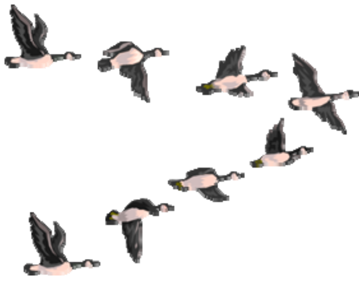


Echelon Academy

Medication & Health Record

Medications your child requires during School:

Medication	Strength	Amount (puffs, tabs, caps, ampules, tsp, cc)	Regular or as needed?	How often?				Specific Instructions
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

____

____

____

____

Is your child on allergy injections? ____Yes ____No
****NOTE:** No allergy shots will be given at school (unless there are special circumstances).

Does your child use an inhaler? ____Yes ____No

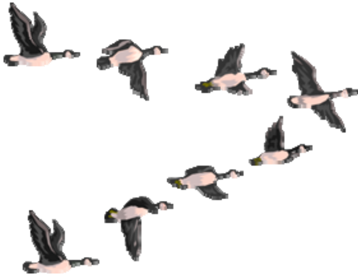
Is there any medication treatment you prefer not be used at school for you child?

____

Does your child have Asthma? ____Yes ____No

Does your child have a specific Asthma Action Plan? ____Yes ____No
If so, please attach to this form.

Who is responsible for giving your child's asthma medication at home?
____Child ____Parent ____Both



On a scale of 0-10, how bad (severe) has your child's asthma been over the last year? (CIRCLE ONE NUMBER ONLY!) (NO ASTHMA) 0 1 2 3 4 5 6 7 8 9 10 (SEVERE ASTHMA)

Describe any emotional effects you have observed in your child due to asthma:
____
____
____

HISTORY OF ALLERGIES - *to be completed by parent and preferable verified by physician*

Is our child allergic to any MEDICATION? (Penicillin, sulfa, etc.)? ____Yes ____No
If yes, please list:

Medication Name	**Reactions*** *(be specific with the symptoms, how severe, when they start, etc.)*	**Age of Last Reaction**

Is our child allergic to any FOODS? ____Yes ____No
If yes, please list:

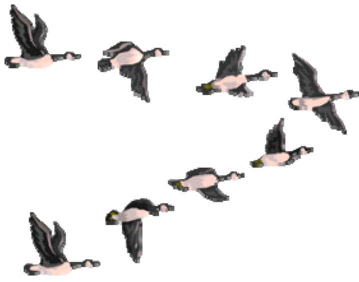
Food Name	**Reactions*** *(be specific with the symptoms, how severe, when they start, etc.)*	**Age of Last Reaction**

Is our child allergic to any ANIMALS? ____Yes ____No
If yes, please list:

Animal	**Reactions*** *(be specific with the symptoms, how severe, when they start, etc.)*	**Age of Last Reaction**

Is our child allergic to any INSECTS? ____Yes ____No
If yes, please list:

Insect	**Reactions*** *(be specific with the symptoms, how severe, when they start, etc.)*	**Age of Last Reaction**



Was emergency treatment needed for any of the reactions listed above (e.g. 911, ER visit, Urgent Care, EpiPen?)? ____Yes ____No

If so, explain

Specifically, does your child have any of the following?

Convulsive Disorders?	____Yes ____No	Heart Disease?	____Yes ____No
Diabetes?	____Yes ____No	Attention Deficit Disorder?	____Yes ____No
Fainting?	____Yes ____No	Learning Disability?	____Yes ____No
Discipline Problems?	____Yes ____No	Obsessive Compulsive Disorder?	____Yes ____No
Hyperactivity?	____Yes ____No	Depression?	____Yes ____No

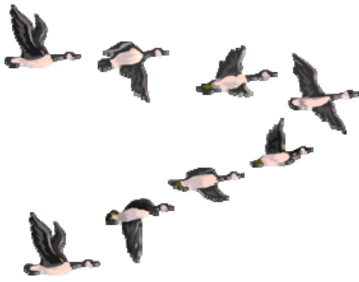
OTHER INFORMATION - *to be completed by parent*

Date of most recent tetanus booster: __________

DPT, Polio and MMR immunizations up-to-date? ____Yes ____No

Are there any other medical problems or conditions your child has that the school should know about?
____Yes ____No
If yes to any of the above questions, explain here:
____
____

Has your child ever been away from home and parents? ____Yes ____No
If so, were there any problems? ____
Do you anticipate any problems with homesickness?
____
Does your child feel embarrassed at school or in public if he/she has to take an inhaler? ____Yes ____No
Do you anticipate any activity restrictions? ____Yes ____No
If so, explain: ____
Are there any present physical education restrictions at school? ____Yes ____No
If so, explain: ____
Is there anything else you feel school staff should know about your child? ____Yes ____No
If so, explain:
____
____



PARENT'S AUTHORIZATION

Date Rec'd________________

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in school , held school year 20_______, sponsored by ____*Echelon Academy*, as parent/guardian I hereby release the Association, its Incorporators, Physicians, Board Members, Officers, Employees, Agents, Independent Contractors and Volunteer Workers from any liability for injuries which are sustained during the school, **including any necessary transportation**. The child herein described has permission to engage in all scheduled activities except as noted by the physician or parent/guardian. I hereby give permission to the school to initiate and provide any necessary treatments, including transporting to the nearest certified emergency facility. If hospitalization is required, the child is to be referred to an appropriate physician and all treatments will be at my expense.

Name __________________________ Relationship to child ___________________ Phone (_____)____________
Please Print

_____________________________________ ______/______/__________ Work Phone (_____)____________
Signature of Parent or Guardian Date