



Little Red School House & Elisabeth Irwin High School

272 Sixth Avenue, New York, NY 10014

Tel: 212-477-5316 Fax: 212-677-9159

Send completed form to address above



THIS FORM MUST BE COMPLETED AND RETURNED BEFORE SCHOOL BEGINS



Student's name: _____ Date of birth: _____ Grade: _____

❖ PERMISSION FOR NURSE TO GIVE OTC MEDICATION ❖

I authorize the school nurse to administer the following over-the-counter medications, as needed and as per package dosage and schedule recommendations, to the above-named upon the request of the student with permission of the student's parent or guardian:

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen (<i>Tylenol</i>) | <input type="checkbox"/> Antihistamine (<i>Benadryl</i>) |
| <input type="checkbox"/> Ibuprofen (<i>Advil / Motrin</i>) | <input type="checkbox"/> Antibiotic Ointment (<i>Bacitracin</i>) |
| <input type="checkbox"/> Robitussin (<i>Guaifenesin</i>) | <input type="checkbox"/> Other over the counter medication |
| <input type="checkbox"/> Cough drops / Lozenges | <input type="checkbox"/> DO NOT give ANY medication |
| <input type="checkbox"/> Antacid (<i>Tums, Maalox</i>) | |

❖ Physician / Healthcare Provider signature (required)

❖ Parent signature (required)

❖ CONSENT TO SHARE INFORMATION ❖

The School Nurse has permission to share information provided in this report with appropriate members of the educational team for use in meeting the health and educational needs of the student. This will be done only on a "need to know" basis, in a confidential manner. This would include permission for communication between the Physician / Healthcare Provider and the School Nurse to facilitate this process.

Parent/Guardian signature required _____

Consent given? yes no

To be completed by the Physician / Healthcare Provider:

Allergies (please describe allergic reactions and give treatment plan): _____

Asthma (please give treatment plan): _____

Special medications: _____

Student's name: _____

Grade: _____

❖ **SCREENINGS AND TESTS** ❖

1. VISION: Test date: _____

Right (O.D.): _____ Left (O.D.): _____ Both (O.D.): _____

Fusion: pass fail Color: pass fail Wears glasses? no yes Contact lenses? no yes

Any issues we should be aware of? no yes , please explain _____

2. HEARING: Test date: _____

Audio/Sweep: pass fail Threshold: _____ Corrective devices? no yes

Any issues we should be aware of? no yes , please explain _____

3. PPD MANTOUX TEST FOR TB - Required for all students newly entering the NYC school system at the secondary level.

Date tested: _____ Date interpreted: _____ Results: _____ mm

Abnormal results? Please explain and describe treatment: _____

4. HEMATOCRIT/HEMOGLOBIN:

Date tested: _____ Results: _____%, _____ . _____

5. SCOLIOSIS - SCREENING REQUIRED BY NEW YORK STATE:

Date tested: _____ Results: _____

❖ **PHYSICAL EXAMINATION** ❖

Height: _____ Weight: _____ Body Mass Index: _____

Blood Pressure: _____ Menarche: no yes , date: _____

Normal Physical Exam: no yes

Diagnoses, Problems, Clinical impressions, Significant medical history:

1. _____
2. _____
3. _____
4. _____

Follow-up? no yes , specify referral and date: _____

IMMUNIZATION HISTORY

	Date immunization given				
	1st	2nd	3rd	4th	5th
DTP					
DT					
DTaP					
Hib					
OPV/IPV					
Hep B					
MMR					
Varicella					
Other, specify:					

Date of exam: _____

Physician / Healthcare Provider's Signature

Name (PLEASE PRINT)

Telephone No. _____

Address: _____
