CHERRY HILL PUBLIC SCHOOLS ENVIRONMENTAL EDUCATIONAL RESIDENCY PROGRAM
Health Information Form

Student information: **Week attending Mt. Misery (circle one) : 10/2 10/9 10/16**

Student's last name	Student's first name	Date of birth	LC/Advisor

Street address	Home phone

Parent/Guardian information:

Name	Relationship	Primary day time phone	Primary evening phone
Name	Relationship	Primary day time phone	Primary evening phone

Emergency contact information:
List two nearby neighbors or relatives who would assume responsibility for your child if we cannot reach you:

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

Medical information:

Please complete the items listed below. If not applicable, please put "N.A" on the line provided.

1. Student's Physician: _____
   Name: Phone number
2. Date last tetanus booster was given: _____
3. List any allergies to foods, medications, insect bites, etc.
   _____
   _____
4. Has the student been exposed to any illness in the past month? If so, what was the illness and when?
   _____
5. Please comment if there is any additional information that we should be aware of so that your child's experience can be successful. _____
   _____
   _____
6. **MEDICAL EMERGENCY:**

   In the event I cannot be reached, I hereby give my permission to the physician selected by the school to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child. I understand that every effort will be made to contact the parent/guardian and the physician of the participant.
   NJ State Law requires that this statement be signed for admittance to the environmental resident facility.

   PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

PLEASE COMPLETE BOTH SIDES OF FORM.

Cherry Hill Public Schools

ACETAMINOPHEN/IBUPROFEN AUTHORIZATION FORM

School Year: _____

New Jersey State law allows for the administration of acetaminophen (Tylenol) and/or ibuprofen (Advil/Motrin) at school. The medication dosage will be based on your child's weight and be administered by the School Nurse in accordance with the establish protocols developed by the school physician. In order for your child to receive this medication at school, this form must be completed and signed each school year. ***NO VERBAL PERMISSION WILL BE ACCEPTED.***

Please note: Only one dose will be given per school day and will not exceed two doses per week.

If you anticipate that your child may require a different dose to achieve analgesic relief or may require acetaminophen or ibuprofen more than twice per week, then you must obtain an order from your child's physician (see Consent for Prescribed Medication).

Name of Student: _____ Date of Birth: _____

Grade/Team/Graduation Year: _____

School: _____ Teacher: _____

☐I give permission for my child _____ to receive (**CHOOSE ONE**)

☐ Acetaminophen

☐ Ibuprofen

☐ I do **NOT** give permission for my child to receive Acetaminophen or Ibuprofen at school.

I understand that a generic equivalent may be used. I understand that the dosage administered will be a **weight-based dose** in accordance with the established protocols developed by the school physician and in accordance with the Cherry Hill Public School medication policy. I understand that a maximum of one dose can be given per school day and will not exceed two doses per week.

MEDICATION HISTORY:

Is your child allergic to any medication? ☐ Yes ☐No

If yes, please list the medication (s) and type of reaction: _____

_____

Does your child take any prescription or over the counter medication on a regular basis? ☐ Yes ☐No

If yes, please list: _____

_____

PARENT SIGNATURE: _____ **Date**: _____

_____

Dr. Eric Requa, School Medical Director, Cherry Hill Public Schools

Date: 5/1/18

✱ SAMPLE ✱

NAME OF STUDENT: John Smith LC 1

MEDICATION POLICY FOR THE CHERRY HILL ENVIRONMENTAL EDUCATIONAL RESIDENCY PROGRAM

- All medications including over the counter medications require a doctor's written order.
- The only exception is Acetaminophen (Tylenol) and Ibuprofen (Advil or Motrin) which can be given with the permission of a parent/guardian.
- All medication must be labeled clearly and given to the school nurse one week BEFORE the day of departure.
- Medications MUST be in the original pharmacy bottle with the label intact. Do not include extra doses. It must be in a large ziplock bag with the student's name, LC and date of trip.
- ONE MEDICATION FORM SHOULD BE USED FOR EACH MEDICATION. Additional sheets can be obtained from the nurse's office or downloaded off the nurse eboard.

1. PRESCRIPTION/OVER THE COUNTER MEDICATIONS:

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE Carol Smith

PHYSICIAN'S ORDERS (please print)

Name of Student: John Smith

Diagnosis: allergies

Medication: Xyzal

Dosage and Time: 5mg at bedtime

Comments:

PHYSICIAN'S SIGNATURE: Dr. Jones MD

2. PRESCRIPTION/OVER THE COUNTER MEDICATIONS:

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE Carol Smith

PHYSICIAN'S ORDERS (please print)

Name of Student: John Smith

Diagnosis: hives

Medication: Benadryl

Dosage and Time: 25mg every 6 hrs. as needed

Comments:

PHYSICIAN'S SIGNATURE: Dr. Jones. MD

NAME OF STUDENT: _____ **LC** _____

MEDICATION POLICY FOR THE CHERRY HILL ENVIRONMENTAL EDUCATIONAL RESIDENCY PROGRAM

- **All medications including over the counter medications require a doctor's written order.**
- **The only exception is Acetaminophen (Tylenol) and Ibuprofen (Advil or Motrin) which can be given with the permission of a parent/guardian.**
- **All medication must be labeled clearly and be brought by a PARENT/GUARDIAN to the school nurse at least one week BEFORE the day of departure.**
- **Medications MUST be in the original pharmacy bottle with the label intact. Do not include extra doses. It must be in a large ziplock bag with the student's name, LC and date of trip.**
- **ONLY ONE MEDICATION SHOULD BE LISTED IN EACH PHYSICIAN ORDER AREA. See sample in packet. Additional sheets can be obtained from the nurse's office or downloaded off the nurse eboard.**

1. **PRESCRIPTION/OVER THE COUNTER MEDICATIONS:**

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN'S ORDERS (please print)

Name of Student: _____

Diagnosis: _____

Medication: _____

Dosage and Time: _____

Comments: _____

PHYSICIAN'S SIGNATURE: _____

2. **PRESCRIPTION/OVER THE COUNTER MEDICATIONS:**

I request the enclosed medication to be administered to my child according to the physician's written orders which will accompany the medication.

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN'S ORDERS (please print)

Name of Student: _____

Diagnosis: _____

Medication: _____

Dosage and Time: _____

Comments: _____

PHYSICIAN'S SIGNATURE: _____