Butler High School Health Services
38 Bartholdi Ave, Butler, NJ 07405
973-492-2000 x281

ANNUAL HEALTH UPDATE

Child's Name _____________________________ Grade_____________________

Has your child had any serious accidents, injuries, illness, or surgery over the summer? ____ If yes, please explain ____________________________________
____
____

Is your child allergic to anything? __________ If yes, please list and explain _____
____

Is your child taking any medications for any reason? _______________________
Medication: ____
Reason: ____
Does you child have any medical or physical problems (i.e. diabetes, seizures, asthma, bleeding tendencies, headaches, fatigue, nosebleeds, physical limitations)?
Please explain:____
____

If your child has **asthma**, please explain the care required:
____
____

Does your child wear glasses? ______ Contacts? _________
When does your child need to wear glasses? __________________________________
Date of last exam: _______________ Date of last prescription change: ___________
Is there any additional information about your child's health, development, behavior, family or home life you want the school to be aware of?
____
____

Any new immunizations? ______ If yes, please attach a doctor's note with the type, month, day and year given.

As a parent/guardian of above named student, I hereby authorize the release of pertinent medical information (conditions, allergies, treatment regimes) to be exchanged among appropriate professional staff involved in the care of above named student. This consent is valid in the Butler School District and is intended to allow staff to better serve my child.

Signature Parent/Guardian: ____
Date: ________________________________
Please list an email address where you can be contacted in a confidential manner.

Butler High School
38 Bartholdi Avenue, Butler New Jersey, 07405
Telephone: 973-492-2000 Fax-: 973-492-8672 www.butlerboe.org

REQUEST FOR MEDICATION ADMINISTRATION BY A SCHOOL NURSE

Student's Name_____________________________Date of Birth____________________

Parent/Guardian's Name_____________________Telephone #_____________________

To Be Completed By Physician

I certify that the above named student has the illness specified below, is physically fit to attend school, and is free of contagious disease. I further certify that the student will not be able to attend school if the medication is not administered during school hours.

Name of Illness____

Name and Purpose of Medication____

Prescribed Dosage and Time to be Taken_____________________________________

Medication to Start:__________________**Medication to Stop:**___________________

Possible Side Effects:____

Physician's Name_________________________**Telephone#**_____________________

Physician's Signature_______________________________**Date**__________________

To be Completed by Parent or Guardian

I request that the School nurse administer to ___________________________________
the medication prescribed by the Physician listed above.

Signature of Parent/Guardian____________________________Date_________________