ACADEMIES @ GBDS
Gerrard Berman Day School

HEALTH AND MEDICAL RECORDS 2020-2021 SCHOOL YEAR

Student Name _____ **DOB**_____ **M/F** _____ **GRADE**_____
Address _____
Physician's Name _____ **Phone Number** _____ **Chart #** _____

EMERGENCY CALL INFORMATION (parent/guardian is called first unless otherwise requested)
Mother/Guardian: _____ **Work #:** _____ **Cell #:** _____
Email: _____
Father/Guardian: _____ **Work #:** _____ **Cell #:** _____
Email: _____

Additional emergency names and phone numbers - **please click here to fill out this form**
Emergency contacts are expected to be reachable immediately and must be available to pick up the sick student within one hour of being called by the school if they are informed of student illness.

EMERGENCY MEDICAL INFORMATION (to be completed by parent/guardian)
ALLERGY: (food, medicine, insect toxin, other): _____
Medication used for allergies: _____ Allergy medication sent to school: YES* ☐ NO ☐
HISTORY OF: Asthma ☐ Convulsions ☐ Headaches ☐ High fevers ☐ Stomach issues ☐
Other medical conditions: _____
Any condition requiring medication Medications being sent to school: YES* ☐ NO ☐
If yes, Page 3 must be completed and signed by both parent and doctor
Does your child wear: glasses ☐ contact lenses ☐ braces ☐ hearing aide ☐

*If any medication is coming into school, it must be accompanied by a form signed by both the physician and parent (Consent for Medication Form). The form should state the student's name, the medication name, reason given, amount to be given and time to be given. Prescription and "over the counter" medications must be in original,labeled bottles or containers. For prescription medications, pharmacies will provide a duplicate labeled empty bottle which can be sent to school with the medication. Additional forms available at the School.

AUTHORIZATION:
In the event my child requires emergency medical care (as determined by the School Nurse/ Leadership) while he/she is under School jurisdiction, I authorize the doctor(s) and hospital to which my child is brought to perform all necessary emergency procedures and render treatment including the administration of anesthesia as necessary. I understand that attempts will be made to contact parents/guardians (and the emergency numbers listed on this form as necessary) before initiating this authorization.

Date: _____ **Parent or Guardian Signature:** _____

***Please return this form to:**
Academies @ GBDS School Nurse
45 Spruce Street, Oakland, NJ 07436 PHONE #: 201-337-1111 FAX#: 201-337-7795 email: nurse@ssnj.org

ACADEMIES @ GBDS
Gerrard Berman Day School

Student Name _____ **DOB**_____ **M/F** _____ **GRADE**_____

Address _____

Physician's Name _____ **Phone Number** _____ **Chart #** _____

*** IMMUNIZATIONS – Please *attach current immunization record***

MEDICAL HISTORY:
to be completed and signed by doctor

Date of Last Physical Exam: _____ (based on a physical performed within the past 12 months)
Height _____ Weight _____ Vision _____ (pass/refer)
B/P _____ Pulse _____ Hearing_____ (pass/refer)

MEDICAL CONDITION(S):

_____

_____

ALLERGIES:
attach current Allergy Action Plan, if applicable)
Medication(s): _____
Food: _____
Other: _____

MEDICATION(S) CURRENTLY PRESCRIBED/USE:
attach current Asthma Treatment Plan OR Epi Pen Care Plan, if applicable

_____

_____

_____

ACTIVITY RESTRICTIONS:

_____

OTHER:

_____

PHYSICIAN'S SIGNATURE: _____ **DATE:**_____

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MEDICATION CONSENT FORM 2020-1021

New Jersey State Law requires the use of a written consent form in order to dispense any medication in school. This includes all over- the- counter medications (Tylenol, Advil/Motrin, decongestant, cough medicines, eye drops, etc.) as well as all prescription medications. This form **must be signed by both the parent and the doctor**; there can be **no exceptions** and **no telephone (verbal) permission**. Under no circumstances will medication be dispensed without proper documentation. This permission form will remain in effect for the entire school year indicated (Sept- June). Any medication sent to school must be in the **original** container that is appropriately labeled by the pharmacy or manufacturer. **A new form must be filled out for each new school year.** A new form will be completed if additional medications are requested during the school year.

*** If you want **no** medications available to your child during the school year, write "NONE" across the form, sign and return it to the Nursing Office.

NAME OF STUDENT: _____ **GRADE:** _____

PRESCRIPTIONS - DAILY ADMINISTRATION OR AS NECESSARY:

Name of Medication: _____ Dosage/ Frequency: _____
Reason for administration: _____
Time of administration: _____ Give if early dismissal: Yes____ No_____
Possible side effects: _____

Name of Medication: _____ Dosage/ Frequency: _____
Reason for administration: _____
Time of administration: _____ Give if early dismissal: Yes____ No_____
Possible side effects: _____

OVER THE COUNTER - AS NECESSARY MEDICATIONS:

Acetaminophen: Dosage/ Frequency: _____ Reason for administration: _____
Ibuprofen: Dosage/ Frequency: _____ Reason for administration: _____
Tums or Pepto-Bismol: (*Circle choice)* Dosage/ Frequency: _____ Reason for administration _____
Other OTC Medication: _____
Dosage/Frequency: _____ Reason for Administration_____

***The School Nurse or Leadership/ Administrator will make the effort to contact a parent/guardian prior to administering an "as necessary" medication as listed above. By signing below, the parent/guardian agrees to indemnify, hold harmless, and defend Academies @ GBDS, Gerrard Berman Day School rom all and any claims demands, actions, damages, losses, threats of loss, liabilities and other costs incurred by Academies @ GBDS, Gerrard Berman Day School arising from the administration of medication as set forth in this Medication Consent Form, below.*

I authorize the school nurse to administer the above medications as necessary.

****Parent/ Guardian:** _____ **Date:** _____

****Physician:** _____ **MD STAMP:** _____

MUST BE SIGNED BEFORE ADMINISTERING ANY MEDICATION

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