HEALTH RECORD FORM

Northern Illinois University, Lorado Taft Campus
(815) 732-2111, extension 120

Student's Name_____

School_____

My child will attend the Lorado Taft Field Campus from _____to_____

Date of Birth _____ Age_____ Weight _____ Male____ Female____ Home Phone _____

Address_____
Street City State Zip

Name of Parent or Guardian_____ Home Phone_____ Work/cell_____

Name of Parent or Guardian_____ Home Phone_____ Work/cell_____

Alternate Contact name and number _____

Child's physician _____Physician's phone_____

The answers to these questions will be kept confidential. The purpose of these questions is to provide our nurse with health and safety information about your child.

1. ***See back side of form if child has asthma, an epi-pen, requires an injection or nebulizer, or has a doctor's excuse from PE activities.***
2. Date of last tetanus booster: _____
3. Is your child presently under a doctor's care? ____Yes ____No
4. Medical information the **Taft nurse** should know (allergy, illness, physical disability, sleep walker, bedwetter, etc.)

_____

_____

4. **SPECIAL DIET** (vegetarian, diabetic, food allergies, etc.)_____

5. **MEDICATIONS** - *I hereby give permission for my child to take medication at Lorado Taft Field Campus under the supervision of authorized personnel. All medication must be brought in a container appropriately labeled by a pharmacy or physician and clearly marked with the child's name and instructions for administering. IF YOUR CHILD IS PUT ON MEDICATION AFTER THE HEALTH FORM IS TURNED IN--SEND A NOTE WITH NAME, INSTRUCTIONS, AND PARENT SIGNATURE.*

PLEASE LIST Medication(s)	Directions for administering (specify am or pm)		
_____	_____	☐ am	☐ pm
_____	_____	☐ am	☐ pm
_____	_____	☐ am	☐ pm

"OVER THE COUNTER" Medications approved for student (please checkmark each type for approval):

☐ **Acetaminophen** ☐ **Ibuprofen** ☐ **Hydrocortisone cream** ☐ **Cough drops**

☐ **Benadryl** ☐ **Claritin** ☐ **Triple Antibiotic Cream**

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I give permission to have my child treated by the Lorado Taft Campus nurse, or by a physician in case of an emergency.

Signature of parent or guardian_____ **Date**_____

MEDICATIONS TO BE ADMINISTERED BY AUTHORIZED PERSONNEL SHOULD BE GIVEN TO THE TEACHER/COORDINATOR BEFORE DEPARTURE TO ENSURE SAFE ARRIVAL AT LORADO TAFT FIELD CAMPUS.

PLEASE COMPLETE ONLY IF CHILD HAS THE FOLLOWING CONDITIONS:
PE EXCUSE/ASTHMA/EPIPENS/INJECTIONS

NAME: _____ **GRADE:** _____

IF child is EXCUSED from PE for any reason, YOUR PHYSICIAN NEEDS to fill out, sign this release. MD initials X _____
Name _____ has my permission to participate in outdoor education.
Any limitations must be listed below:

_____

_____

ASTHMA/INHALER SECTION

Medication/Inhaler _____Dosage _____q_____Hours

Neb Treatment – Name/Medication _____Dosage_____q_____Hours

ASTHMA ACTION PLAN Peak flow meter – My Personal Best = _____

Green Zone – Breathing is easy, can play, work without symptoms **PEAK Flow Range 80%-100% of Personal Best**
Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____
Yellow Zone – Breathing easy, coughing or wheeze, chest tight, SOB **PEAK Flow Range 50%-80% of Personal Best**
Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____
Red Zone – Medicine NOT working, nose open wide to breath, breathing is hard and fast, trouble walking and talking, ribs show
IF SYMPTOMS DO NOT GET BETTER – CALL 911 **PEAK Flow Range below 50%**
Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____

EPIPEN EMERGENCY PLAN SECTION Please note: each body system must be filled out

Allergic to: _____

Medication & Dosage:

☐ **Epipen 0.3mg** ☐ **Epipen Jr. 0.15mg** ☐ **Twinject 0.3mg** ☐ **Twinject 0.15mg** ☐ **Benadryl** ☐ **25mg** ☐ **50mg po**

Treatment:

Mouth: Itching, tingling, or swelling of lips, tongue, mouth	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
Skin: Hives, itchy rash, swelling of the face or extremities	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
Gut: Nausea, abdominal cramps, vomiting, diarrhea	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
Throat: Tightening of throat, hoarseness, hacking cough	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
Lung: Shortness of breath, repetitive coughing, wheezing	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
Heart: Thready pulse, low blood pressure, fainting, pale, blueness	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
Other: _____	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**
If reaction is progressing (several of the above areas affected)	**GIVE**	**____ EPIPEN**	**____ TWINJECT**	**____ BENADRYL**

CALL 911, CALL PARENTS

OTHER INJECTIONS: Please list below or send a separate physicians order.

_____

_____

Self-Administering Exception: ***Students with emergency-use inhalers, epi-pens and glucagon injections must carry them at all times.***

_____ _____

Physician Signature – Date **Parent Signature – Date**

(only needed if IM [including Epi Pens, diabetic injections, growth hormones, etc.], SubQ, nebulizer treatment, excuse from PE or if your school requires it