



CHELMSFORD COMMUNITY EDUCATION

170 Dalton Road

Chelmsford, Massachusetts 01824

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Summer 2010

Dear Parent and/or Guardian:

It is the policy of Chelmsford Community Education Summerfest Program and the Special Education Summer School to administer medication during the day only when necessary. If at any time while your child is enrolled in these programs a medication is required please refer to the following:

The nurse will need the appropriate orders and/or consents in order for your child to receive a medication. These forms can be found on the Community Education web site. Please note that these orders and/or consents must be submitted each new enrollment period.

- **Health Information Form** – This needs to be completed for those children who have any medical conditions. Please also complete the Medication Order Form if you are providing any medications while your child is enrolled.
- **Signed Medication Order Form** – This needs to be obtained and returned for both prescription and non-prescription medications. If this applies, please also fill out the Health Information Form.

All medications must be delivered to the nurse at the Community Education program and picked up by a responsible adult. All medications will be disposed of at the conclusion of the program if they are not picked up by the last day of the Community Education program.

All prescription medication must be in a pharmacy labeled bottle that includes the child's name, name and correct dose of the medication, physician's name and current date. Please ask your pharmacy to provide you with separate bottles. No more than a 30-day supply can be delivered at one time. All non-prescription medications must be in the original manufacturer's container/packaging.

Please call with any questions or concerns.

Thank you for your cooperation.

The Nursing Staff

CHELMSFORD COMMUNITY EDUCATION HEALTH INFORMATION

08/09

Name _____ Birth Date _____ M ___ F ___
Last First M.I.

Address _____ Telephone _____

Mother's Name _____ Telephone#s _____

Father's Name _____ Telephone#s _____

With whom does the child reside? _____

Additional names and phone numbers to contact in case parent cannot be reached:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Doctors to be notified in case of severe injury:

M.D. _____ Telephone _____

Dentist _____ Telephone _____

Eye Doctor _____ Telephone _____

Hospital you prefer in case of an emergency: _____

PLEASE NOTE: This **MUST** be answered in order for the school nurse to give Tylenol. Weight is required for dosage.

Do you give permission for the school nurse to administer Tylenol to your child? Yes ___ No ___ Child's Weight _____

Is your child being treated for any of the following conditions? Please circle if item applies to your child:

Asthma **Glasses/Contact Lens** **Fainting** **Seizures** **Diabetes** **Kidney problem**
Epilepsy **Heart problems** **Scoliosis** **Gastrointestinal problems**
Allergies: **Bee/Wasp/Hornet** **Seasonal** **Other**

Does your child have a prescribed inhaler? Yes ___ No ___

Date of last tetanus (DPT) immunization: _____

Recently under doctor's care? If so, what for? _____

Has your child had recent surgery? If so, what type? _____

Additional comments or problems: _____

Medications:

All medications must be given to the school nurse. Medications for temporary illness or condition will be administered by the school nurse only if medication is received in the original prescription or over-the-counter container and is accompanied by written authorization. List medication(s) your child takes regularly:

I authorize the release of school records to the appropriate school personnel as necessary for health and safety.

Parent's Signature _____ Date _____

PLEASE COMPLETE THE OTHER SIDE ALSO.

**CHELMSFORD COMMUNITY EDUCATION
HEALTH INFORMATION, continued**

Name of Child: _____
PLEASE PRINT(last) (first)

Birth Date: _____ Birthplace: _____

Primary language spoken at home: _____

Names and ages of other children at home: _____

IDENTIFYING INFORMATION:	
EYE COLOR _____	HAIR COLOR _____
HEIGHT _____	WEIGHT _____
SEX _____	RACE _____
IDENTIFYING MARKS _____	

Does your child have any medical constraints which would limit his/her activity while at school? Yes ___ No ___

If yes, please explain: _____

Who will pick up your son/daughter? _____

Names of others who may occasionally pick up: _____

PLEASE COMPLETE THE OTHER SIDE ALSO.

