The Rise School™
OF HOUSTON
"Where All Kids Shine"™

Physician's Health Assessment and Non-Prescription Medication Order

(To be completed annually)

This form must be returned to The Rise School of Houston on or before August 1st. Per childcare licensing mandates, children cannot be permitted to attend our program without this annual form on file.

_____ _____
CHILD'S NAME **DOB**

- Date of Last Well Child Check Up:_____ Weight:_____ Height:_____
- Are immunizations current? _____Yes _____ No; reason:_____
  Please attach a copy of the current immunization record.

Developmental Diagnosis(es): _____

Medical Diagnosis(es): _____

Medications prescribed for any conditions listed above: _____

_____

Vision: Date of most recent exam: _____ Results:_____ Where tested? _____

Hearing: Date of most recent exam: _____ Results:_____ Where tested? _____

- **This child is cleared to participate in a program with other children.**
- **This child is cleared to have an OT/PT/Speech evaluation and/or therapy, if indicated, by appropriately licensed therapists**.

Please list any contraindications and/or cautions for participation and/or evaluation:_____
_____

_____ _____
Physician's Signature Date

_____ _____
Printed Name Phone

_____
Address City Zip

OVER

The following non-prescription medications and treatments may be administered with the authorization of both the child's physician and parent. Any administration is at the discretion and clinical judgement of the School Nurse who may also delegate administration to a trained designee. All listed medications and treatments will be administered according to packaging directions and/or weight based dosing tables from the American Academy of Pediatrics unless otherwise ordered by the child's physician.

Patient Name: _____ DOB: _____

Name	Indication	Parent Permission (Please circle)
*Acetaminophen (Tylenol) 160 mg/5 mL	Fever, Acute pain	Yes No
*Ibuprofen (Motrin) (6 months of age or older) 100 mg/5 mL	Fever, Acute pain	Yes No
*Diphenhydramine (Benadryl) 12.5 mg/5mL	Mild allergic reaction *For known anaphylactic allergies, an Emergency Action Plan and rescue medication(s) must be provided.*	Yes No
Calamine, Zinc Oxide	Skin irritation, Insect bites/stings	Yes No
Aquaphor, Vaseline (petroleum jelly)	Dry/Chapped skin or lips, minor skin irritation	Yes No
Topical Hydrocortisone 1% cream	Insect bites/stings, mild skin irritation	Yes No
Antiseptic Cleansing Liquid with 2% Lidocaine	Wound cleansing	Yes No
Sodium Chloride USP 0.9%	Wound cleansing	Yes No
Eyewash Ophthalmic Solution	Eye irritation, foreign body removal	Yes No

Physician Use Only

My signature below constitutes an order to administer the above listed medications to my patient as indicated unless otherwise noted by me.

_____ _____
Physician's Signature Date

_____ _____
Printed Name Phone

_____
Address City Zip

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Parent Authorization

By circling Yes or No above, I consent or decline permission for my child _____ to receive the medications and/or treatments above. I understand I will be notified in the event my child receives any of the above medications and/or treatments.

_____ _____ _____
Parent Signature Parent Name Date