Dayspring Christian Academy Health Profile and Consent to Standing Orders
2026-2027 School Year

Student:_____ Grade:_____ Date of Birth:_____

Please List TWO (2) Emergency Contacts:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Health Concerns that the School Nurse or Teacher should be aware of?

-Allergies? Yes No -Emergency Medication needed, such as epinephrine(Epi-pen)?_____

Bee Peanut Tree Nuts Egg Milk/Dairy Shellfish Latex Environmental Seasonal

Other, including Drug Allergies (please specify):_____

-Asthma? Yes No -Does the student use an inhaler?_____

-**Seizure Disorder?** Yes No -Emergency Medication needed/which med?_____ Date of last seizure?___

-Diabetes? Yes No :Type 1 Type 2

-Lactose Intolerance? Yes No -Medication needed at school? Yes No

Vision: Glasses Contacts Other:_____

Hearing Loss: Yes No **Hearing Aids:** Yes No

Annual Health Update:

Serious illness, injury, hospitalization or operation during the **past year**? Yes No

Describe:_____

Is your child still under treatment? Yes No

Restricted from physical activity? (Written restrictions signed by a doctor are required) Yes No

Describe:_____

Special Diet and/or have a specific food restriction? Yes No

Describe:_____

Recent changes we should be aware of? (Separation, Divorce, Illness, Death, etc.) Yes No

Describe:_____

Other Health Concerns: check all that apply

- ☐ ADD/ADHD
- ☐ Heart Condition
- ☐ Kidney Disorders
- ☐ Neurologic Disorders
- ☐ Sickle Cell Anemia
- ☐ Headaches or Migraines
- ☐ Bleeding Disorders
- ☐ Weight or Eating Disorder
- ☐ Cancer
- ☐ Concussion/Head Injury
- ☐ Anxiety and/or Depression
- ☐ Developmental Issue (autism, learning disabilities)
- ☐ Cystic Fibrosis
- ☐ Muscular Dystrophy
- ☐ Digestive/Stomach Condition
- ☐ Musculoskeletal or Orthopedic Conditions
- ☐ Skin Conditions
- ☐ Immunodeficiency
- ☐ Behavioral Issue

List any other Medical Conditions or include more information if needed: _____

_____

List all Medications and Doses:_____

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Please review the list of medications/treatments that are included in the School Standing Orders. Medication will be given as directed by the manufacturer unless otherwise directed by a physician. Please indicate Yes/No and initial each medication/treatment.

Medication/Treatment	**Purpose**	**Yes/No**	**Initial**
Acetaminophen (e.g. Tylenol)	Mild pain/headache,fever		
Ibuprofen (e.g. Motrin, Advil)	Mild-moderate pain/headache, muscle pain, inflammation		
Antacid (e.g. Tums)	Upset stomach,heartburn		
Topical Ointment/Cream (e.g. bacitracin, vaseline, sting relief, first aid cream)	Minor cuts, scrapes, abrasions, bee sting		
1% Hydrocortisone Cream	Minor insect bites, rashes		
Non-Medication Treatment (e.g. ice/heat pack, saline eye wash, lotion, salt water gargle, aloe vera gel, cough drops)	Minor injuries, irritations		
Diphendydramine (e.g. Benadryl)	Mild-Moderate allergic reaction to food, insect bite or contact		
Cetirizine(Zyrtec)/Fexofenadine(Allegra)	Mild allergies, localized itching or mild rash, itchy running nose, sneezing, itchy watery eyes		
Lubricant eye drops (e.g. Refresh)	Eye irritation, minor discomfort or contaminant clearance		
Oxymetazoline (e.g. Afrin)	Persistent nosebleed		

- I **authorize** the licensed School Nurse to administer the medications/treatments that I have initialed according to the School Physician's Standing Orders.
- I agree to inform the school immediately of any changes to my child's health status, allergies, or ongoing medications.
- I understand that: (1) these medications are stocked and maintained in the school health room with standing orders prescribed by the School Physician; (2) I will be notified of the medication and time that the OTC medication was administered to my child; (3) I will be contacted if my child's symptoms do not improve and he or she is unable to remain at school.
- I agree to **hold harmless** and release the School Nurse and the School Physician from liability for any adverse outcome or injury to my child resulting from the administration of authorized medications or treatments under the Doctor's Standing Orders or Emergency Protocols, **provided the school personnel acted in good faith and according to established medical protocols.**
- I understand that this consent is valid for the current school year/program only and must be renewed annually.

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____ Date:_____

SCHOOL REVIEW (To Be Completed by School Staff)

Form Received By: **Date:**