TASIS DORADO

PERMISSION FOR OVER –THE – COUNTER MEDICATIONS

When students are ill, it is often deemed wise to provide them with over-the-counter medication for symptom relief. At TASIS Dorado, the Registered Nurse will decide which medications are indicated and can administer over-the-counter medications to your child. Occasionally, main office administrators will administer over-the-counter medications to students after consulting with the Registered Nurse. If there are any medications that you do not wish your child to have, please follow the instructions below.

Medications needed at the moment will be provided to your child. If your child requires long term use of an over-the-counter medication or any specific prescription medication parents need to provide them to the Registered Nurse Health Office with the required forms. As clearly stated in the TASIS Dorado policy, no medication may be kept in the student's classrooms or backpacks, unless authorized by the School Nurse. This form is only for the medications listed below and will only be administered per manufacturer's recommended dosing.

_____ _____

Student Name Date of Birth

_____

Parent's Name

____ **All Over-the-Counter Medications Below**

____ **No Over-the-Counter Medications Below**

Or indicate which medications may be administered by checking below:

__ Tylenol/Acetaminophen

__Advil/ Ibuprofen

__Claritin/Loratadine

__Benadryl Liquid or tabs

__Cold Tylenol/Cold Relief

__Pepto Bismol

__Dimettap Cold & Allergy

__Cough Syrup

__Tums

__Cough Drops/Halls

__Antibiotic Ointment

__Hydrocortisone / Benadryl Cream

I give permission for the School Nurse to dispense the above checked medicine(s) to my child:

_____ _____

Parent's Signature Date

TASIS
DORADO

PHYSICAL EXAMINATION to be performed by a Licensed Physician.

Puerto Rico State Law #235 requires that all immunization records be kept in the student's file. Please ask your doctor to fill in the PVAC-3 Form (the green form) and return it to School with this document.

Student's Name_____ Age:_____ Grade_____

Birth Date_____ Height_____ Weight_____

General Appearance:_____ Chest and Lungs_____

Eyes_____ Heart_____ Abdomen, Hernia_____

Vision with Glasses: R_____ L_____ Color Vision_____

Hearing: R_____ L_____

Extremities_____ Skin_____ Teeth and Gums_____

Posture, Gait, Spine_____ Coordination_____

Nutrition_____ Blood Pressure_____ Neurological_____

Scalp, Neck, Head_____ Ears_____ Nose_____

Physical and Emotional Challenges _____

_____

Diagnosis and Recommendations _____

_____

_____

Recommended activity for physical education and sports: Full_____ Limited_____

If Limited, Please Explain_____

_____

Physician: _____ License No.:_____

Date: _____

Departamento de Salud
PO Box 70184
San Juan, Puerto Rico 00936
www.salud.gov.pr

CERTIFICADO DE EXAMEN ORAL

Nombre del menor Apellido Paterno	Apellido Materno	Nombre	Inicial	**Sexo** **F**	**M**	**Edad**	**Grado que cursa**

Dirección física	**Dirección postal**	**Teléfonos** ( ) ( )

Nombre del padre, madre o encargado	**Relación con el menor**

EXAMEN ORAL

☐ **SE REALIZÓ EVALUACIÓN ORAL**	**RECOMENDACIONES :**
Fecha: Día / Mes / Año	☐Cuidado dental regular de rutina
☐ Se ofreció orientación de prevención e higiene	☐Necesita tratamiento dental adicional al de rutina
☐ Se refirió al paciente para tratamiento	☐ **URGENTE**

CERTIFICACIÓN DEL PROVEEDOR

Certifico haber provisto las recomendaciones y servicios arriba indicados

Nombre del dentista	**Número de licencia**

Dirección del dentista	**Teléfonos** ( ) ( )

Firma	**Fecha** Día / Mes / Año