Student Health Information

First Name	Middle Name	Last Name	Birth Date	Grade	Legal name if different

Family Doctor's Name ____________________

City ____________________ Phone ____________________

Dentist's Name ____________________ Date of last visit ____________________

Optometrist's Name ____________________ Date of last visit ____________________

Corrective Lenses ○ Wears Glasses ○ Wears Contacts ○ Constantly ○ Near Viewing ○ Distance Viewing

Is your child taking any medication? ☐ Yes ☐ No

If Yes

Name of medication ____________________

Dosage of medication ____________________

Time it is to be taken ____________________

Doctor who prescribed ____________________

List any health problems your child may have (ADD/ADHD, constipation, migraines, allergies, asthma, seizures, diabetes, heart problems, ear infections, sore throats, tuberculosis, bladder infections, menstrual cramps, or positive tuberculin test):

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List any special dietary needs (allergy to milk, diabetic, increase fiber, low cholesterol, etc).

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____

Describe any surgery, serious illness or injury your child had this past year.

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What immunization outside of school did your child have this past year?

____________________ Date of immunization ____________________

Any additional information pertinent to your child's health?

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Please turn page over

Student Health Permission

First Name	Middle Name	Last Name	Birth Date	Grade	Legal name if different

Request for administering generic Tylenol and/or Ibuprofen in school

Medication: Acetaminophen (Generic Tylenol) and/or Ibuprofen
Dosage: Age & Weight Appropriate (Children under 12 will not be given Ibuprofen)
Time to be given: Every 4 to 6 hours as needed
Special Instructions P.O. (chewable or to swallow)
Date to start: First day of school year
Date to End: Last day of school year
Illness or condition causing necessity for medication: minor aches & discomfort, headaches fever above 100 F, or menstrual cramps

My child can be given generic Tylenol ☐ Yes ☐ No
My child by can given generic Ibuprofen ☐ Yes ☐ No

Administering additional medication

Parents - Please ask your pharmacist for a second bottle with a label to send part of medicine to school.

This medicine if furnished by parent or guardian in the original labeled container, including date, name and strength of the medicine and directions for use. This request must be signed by the parent or guardian to authorize giving the medication during school hours.

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from the school and pick up remaining medication and equipment.

Parent's Signature ______________________ Date ____________

Below for school use only

08/23/00
10:00am
CS

Initial ______ Signature ______________
______ ______________
______ ______________