Student Health Information

First Name	Middle Name	Last Name	Birthdate	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):

______

______

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

______

______

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

______

______

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

______ Date of Immunization ______

Any Additional information pertinent to your child's health?

______

______

Please turn page over

Student Health Permission

First Name	Middle Name	Last Name	Birthdate	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 100F, or menstrual cramps

My child can be given Tylenol Yes No

My child can be given generic Ibuprofen Yes No

Administering additional medication

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

This medicine is 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 to 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 effect 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 that 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 who 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/Guardian Signature Date

Below for school use only

08/23/11
10:00 am
CS

Initial Signature

______ ____________________

______ ____________________

______ ____________________