Student Health History/Medication Form
2019/2020 School Year

Student Name____________________DOB_________Teacher/Grade_________________________________

Contacts

Parent/Guardian #1_____________________________Phone_______________________________________
Parent/Guardian #2_____________________________Phone_______________________________________
Emergency Contact #3___________________________Phone_______________________________________

Drug/Food Allergies____
Health History/Concerns____
____

- Has your child seen a dentist in the past 12 months? Yes_____No_____
- Has your child had their eyes checked in the past 12 months? Yes_____No_____
- Does your child wear glasses or contact lenses? Yes_____No_____
- Has your child had a concussion? Yes_____No______
  - Was IMPACT testing done as a result of the concussion? Yes_____No_____

_____**I WILL ALLOW** the school nurse and/or authorized personnel to give my child the following: Ibuprofen, Acetaminophen, cough drops, antacids (Tums), antibiotic/anti-itch skin cream for minor problems.

_____**I DO NOT GIVE PERMISSION** for medication to be given to my child.

Special Instructions____

Parent Signature_______________________________________Date__________________________________

Nurse Signature____Date__________________________________

Please initial and complete the following information if your child will require medication at school.

_____**Medication Policy:** I have read and will comply with the school medication policy.
(Policy located on school website)

Medication	Rx or OTC	Dosage/Frequency	Reason	Special Instruction