Yearly Health Information Form

Student Name:_____ DOB (mm/dd/yyyy):_____ Grade:____ Gender:_____

Best contact for illness or emergency Name:_____ Phone: _____

Primary Physician:_____ Physician's Phone:_____

Dentist:_____ Dentist Phone:_____

Please list all **Medical Conditions/Health Needs** below
(Attach additional pages if necessary)

1._____
2._____
3. _____
4. _____
5. _____
6. _____

Please list all **Medications** taken by the student below
(Attach additional pages if necessary)

	Name	*Dosage*	*Purpose*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Note: A medication form signed by parent and physician is required for all prescription medications to be given at school

My child has **permission** to receive the following medications at school with dosage according to the weight/age of child:

- ☐ **Tylenol (acetaminophen)**
- ☐ **Benadryl**
- ☐ **Advil (ibuprofen)**
- ☐ **Cough syrup**
- ☐ **Antacid**

Please contact the school nurse if you wish to send in other over the counter medications for your student.
The school nurses may use over the counter medication (e.g. antibiotic cream, anti-itch cream, cough drops) at their discretion. If you have objections to the use of these medications on your child, please contact the school nurse immediately.

Does student have medical insurance?	☐ Yes	☐ No	
Has student had a dental checkup in the last year?	☐ Yes	☐ No	
Has student had a well child/adolescent exam in the last year?	☐ Yes	☐ No	
Has a doctor, nurse, or health professional EVER said that your child has asthma?	☐ Yes	☐ No	☐ Don't know
If yes, does your child STILL have asthma?	☐ Yes	☐ No	☐ Don't know
I authorize the school to contact my child's healthcare provider for necessary medical information	☐ Yes	☐ No	

EMERGENCY CARE /TREATMENT: In the event of a serious injury or illness, emergency services will be called and parents contacted as soon as possible. If necessary, the student will be transported to the hospital for treatment.

If you have any questions about this form, please **contact your school nurse.**

Parent/Guardian signature_____ Date_____