Interstate 35 Community School District

Student Name: _____ **Grade:** _____ **Date of birth:** _____

HEALTH INFORMATION

Name of Health Provider: _____ **Phone Number:** _____

Date of most recent physical: _____

Name of Dental Provider: _____ **Phone Number:** _____

Date of most recent exam: _____

Preferred Hospital: _____

	Check next to any condition or illness that applies to your child. Use "Comments" section at the bottom of the page for explanations.
1	□ **Allergies** □ Food _____ □ Medicine_____ □ Insects (please specify)_____ □ Environmental □ Latex □ Other (please specify)_____ **Specify reaction to allergy or allergen** □ Rash □ Swelling □ Hives □ Trouble Breathing □ Vomiting □ Diarrhea □ Local Reaction □ **Takes medication for any allergies: Name medication(s)**_____ Does the child need a special diet? □ Yes □ No (If yes, school requires a prescription from doctor.)
2	□ **Asthma:** List triggers_____ Diagnosed at age_____ □ Takes medication: Name medication(s)_____ Under doctor care now? □Yes □ No **See nurse for Asthma Action Plan**
3	□ **Diabetes:** □ Type 1 □ Type 2 □ Insulin_____ □ Pump □ Pen □ Syringe/Needle **See Nurse with Additional Instructions**
4	□ **Ear Problems** □ Frequent infections □ Tubes, date(s)_____ □ Uses hearing aid
5	□ **Heart condition:** Explain_____ Under doctor's care for this condition? □Yes □ No **Any physical restrictions?** □ Yes □ No If yes, explain_____
6	□ **Migraines:** Is child under a doctor's care for this condition? □ Yes □ No □ Takes medication: Name of medication_____
7	□ **Mental Health/Behavioral diagnosis** _____ □ Takes medication: Name of medication_____
8	□ **Seizures**: Type:_____ Length:_____ Frequency:_____ Medication(s)_____ Triggers/Warning Signs: _____ **See Nurse for Seizure Action Plan**
9	□ **Surgeries**: What for_____
10	□ **Vision** problems: Explain_____ □ Glasses □ Contacts
11	**Additional Medical Diagnosis/Health Problems: (check all that apply)** □ Bleeding Tendencies □ Eczema □ Head Injury □ Urinary Problem □ Bowel Problems □ Epistaxis (bloody nose) □ Speech Problem □ Other (please list below)
12	□ **MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS.**
Comments or other health information_____	

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

FORM VALID 2016-17 SCHOOL YEAR ONLY

Interstate 35 Community School District

Student Name: _____ **Grade:** _____ **Date of birth:** _____

CONSENT FOR OVER THE COUNTER MEDICATION

A registered nurse/certified staff will have the following over-the-counter medication available to give to students according to written protocol and with written parental authorization. Please check which medications your child may receive for minor problems such as a cold, menstrual cramps, headache, sore throat, sore muscles, backache, sprains, upset stomach and rashes. These medications are for occasional use only. If your child requires any medication more frequently please provide medication and a signed parental authorization form.

Check one:

☐ May give **ALL** medications listed ☐ Do **NOT** give any medications ☐ Give **ONLY** medications checked

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☐ **Cough / Sore Throat Lozenge** - 1 lozenge every 2 hours as needed for sore throat and/or cough

☐ **Antacid Chewable Tablets** - take 1 every 2 hours for indigestion, heartburn, nausea, diarrhea

☐ **Triple Antibiotic Ointment** - may be applied as needed

☐ **Lip Balm** - may be applied as needed

☐ **Lubricant Eye Drops** - may be used to remove irritant in eye

☐ **Hydrocortisone 1% Ointment** - may be applied as needed for itching/rash

☐ **Acetaminophen (Tylenol)**-Dose according to age and weight

☐ **Ibuprofen (Motrin/Advil)** – Dose according to age and weight

Please list name and dose of student's prescription medications:

Name/Dose:

_____ _____

_____ _____

_____ _____

Parent/Guardian Signature: _____ **Date:** _____

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