

Hilliard City Schools
HEALTH INFORMATION

Student's Name _____ **Grade** _____

My child has the following serious or chronic health condition(s):

- ___ Asthma - requiring medication* or **EMERGENCY** treatment
- ___ Bee Sting Allergy that requires medication* or **EMERGENCY** treatment
- ___ Severe allergy that requires medication* or **EMERGENCY** treatment
- ___ Activity limitation/restriction
- ___ Heart Condition
- ___ ADD or ADHD (circle)
- ___ Urinary System Disorder
- ___ Diabetes*
- ___ Muscular/Skeletal Disorder
- ___ Hearing Disorder
- ___ SEVERE Environmental Allergy
- ___ Vision Disorder
- ___ Other Serious or Chronic Condition
- ___ Seizure Disorder

Explain: _____

*** Contact the school nurse for the required medication and/or physician authorization forms.

Medications

List all prescribed medications taken on a daily basis at home _____

List all prescribed medications that will be taken daily at school _____

Please refer to the student handbook for rules regarding medication at school. Students in Pre- K through 12th grade must have authorization from the licensed prescriber for all prescription medication. Over the counter medications require prescriber authorization for students in Pre-K through 6th grade only. Over the counter medications may be self administered by students in grades 7-12 following the guidelines in the student handbook.

Student: _____ Date: _____

School: _____ Grade: _____ Preferred Doctor: _____

Parent (s) Names: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

I would like to conference with the school nurse. _____ Yes or _____ No

I understand that this health information may be shared with school staff.

Parent/Guardian Signature: _____

Date _____