Hilliard City School District

CURRENT HEALTH INFORMATION

2019-2020

Complete and return ONLY if your student has medical issues potentially impacting school

Student Name _____

School Hilliard Davidson High School Grade _____ Teacher_____

Guardian: _____ Best Number to call: _____

Guardian: _____ Best Number to call: _____

Check if your student has:

[ ] Bee sting allergy requiring medication or emergency treatment*

[ ] Food allergy requiring medication or emergency treatment *

[ ] Asthma requiring medication or emergency treatment*

[ ] Diabetes*

[ ] Seizure Disorder

[ ] Limitations of activity or restrictions

[ ] ADD or ADHD (circle one)

[ ] Vision Problems

[ ] Hearing Loss

[ ] Heart Condition

[ ] Environmental allergies

[ ] Kidney / Urinary Problems

[ ] Muscle / Skeletal Problems

[ ] Other Conditions (explain _____

_____

List Prescription Medications:

Taken daily at home _____

Taken daily at school _____

Medication Policy Summary Refer to student handbook for complete policy.

Grades K-6 All medications *(prescription & non-prescription) require completing of the Medication Authorization Form* with both physician/prescriber and parent signature*

Grades 7-12 Prescription medications *require completing of the Medication Authorization Form* with both physician/prescriber and parent/guardian signature.* ***Non-prescription medications*** *may be self-administered and require Medication Authorization Form* with only parent/guardian signature*

***** Contact school nurse, school office staff, or go online to District Forms for Medication Authorization Form

If conditions develop or medications change during the year, please contact the school nurse. Information may be shared with staff as deemed necessary by the school nurse.

Do you desire a conference with the school nurse? _____Yes _____ No

Parent/Guardian Signature _____ Date _____