

CURRENT HEALTH INFORMATION

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

Student Name _____

School _____ Grade _____ Teacher _____

Guardian: _____ Best Number to call: _____

Guardian: _____ Best Number to call: _____

Check if your student has:

- | | |
|---|--|
| <input type="checkbox"/> Bee sting allergy requiring medication or emergency treatment* | |
| <input type="checkbox"/> Food allergy requiring medication or emergency treatment * | |
| <input type="checkbox"/> Asthma requiring medication or emergency treatment* | |
| <input type="checkbox"/> Diabetes* | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Environmental allergies |
| <input type="checkbox"/> Limitations of activity or restrictions | <input type="checkbox"/> Kidney / Urinary Problems |
| <input type="checkbox"/> ADD or ADHD (circle one) | <input type="checkbox"/> Muscle / Skeletal Problems |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Other Conditions (explain _____ |
| <input type="checkbox"/> Hearing Loss | _____ |

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 _____