



# ST. COLETTA'S OF ILLINOIS

LT. JOSEPH P. KENNEDY SCHOOL

## Student Health Information 2026-2027

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

*For your child's safety, please list ALL medications taken by your child both at home and school.*

\_\_\_\_\_ My child does not take medications regularly.

Name of Drug	Dosage	Time Taken

I consent to my child receiving non-aspirin analgesic (Acetaminophen or Ibuprofen) for minor discomfort, if need is determined by the nurse. (circle one)    yes    no

I consent to my child receiving Pepto-Bismol for upset stomach, if need is determined by the nurse. (circle one)  
yes    no

**Does your child have any medical or physical conditions? If you respond yes, please explain.**

Allergies (Food/Medicine)\*    yes    no \_\_\_\_\_  
*\*If your child needs to have an Epi-pen at school, we request having 2 on hand\**

Asthma    yes    no \_\_\_\_\_

Diabetes    yes    no \_\_\_\_\_

Gastrointestinal Disorder    yes    no \_\_\_\_\_

Headaches    yes    no \_\_\_\_\_

Heart Problems    yes    no \_\_\_\_\_

Nosebleeds    yes    no \_\_\_\_\_

Seizures    yes    no \_\_\_\_\_

If yes, what type and how often \_\_\_\_\_

Skin Disorder    yes    no \_\_\_\_\_

Vision and/or Hearing    yes    no \_\_\_\_\_

Other    yes    no \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_