



Student Health Information
2023-2024

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** _____