Student Health Information
2024-2025

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**________________