STUDENT MEDICAL INFORMATION

Complete and submit immediately.

STUDENT'S NAME: _____ **GRADE:** _____

Preschool: ☐AM or ☐PM

Please list any HEALTH CONDITIONS and MEDICATIONS for your child that we need to be aware of:

	Yes	No	Explain
Glasses/Contacts/Hearing Aids	___	___	_____
Daily Medications (over the counter)	___	___	_____
Daily Medications (prescription)	___	___	_____
Allergies (any type)	___	___	_____
Heart/Lung Issues/Asthma (Meds)	___	___	_____
Diabetes	___	___	_____
Neurological Problems/Seizures	___	___	_____
Stomach/Kidney Issues	___	___	_____
Skeletal Problems/Scoliosis	___	___	_____
Skin Problems	___	___	_____
Other (please specify).....	___	___	_____
.....	___	___	_____
.....	___	___	_____

Please indicate Yes or No to OVER THE COUNTER MEDICATIONS that you are giving the school nurse permission to administer to your child:

	Yes	No
Acetaminophen (Generic Tylenol)	___	___
Ibuprofen (Generic Motrin/Advil)	___	___
Antacid	___	___
Cough drops	___	___
Antibiotic ointment	___	___
Aloe with/without lidocaine	___	___
Anti-itch cream (Hydrocortisone or Calamine)	___	___
Anbesol	___	___
Heating pad	___	___
Benadryl	___	___

Signature of Parent/Guardian: _____ **Date:** _____