Madison County Public Schools

HEALTH INFORMATION FORM

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

Student Name Last First Middle	Gender ☐ Male ☐ Female	DOB mm/dd/yyyy

Home Phone	Grade	Teacher Name	School Year

Parent/Legal Guardian Name:	Work Phone: Cell Phone:
Parent/Legal Guardian Name:	Work Phone: Cell Phone:

TYLENOL / MOTRIN PERMISSION

Does the school have permission to administer Tylenol (acetaminophen) and/or Motrin (ibuprofen) to your child for headache, minor pain or discomfort as determined appropriate by school personnel?

YES _____ NO _____

_____ _____ _____

Signature **Relationship to Child** **Date**

We do not supply any over the counter medicines such as cough drops, allergy or sinus medicine, Orajel, eye drops, ear drops, TUMS, Pepto-Bismol or reflux meds. You are welcome to bring in an original container of the above meds for your child with his/her name on it, and fill out a permission form. We will keep it in the clinic for them specifically.

☐ ALLERGIES

Allergy Type:

☐ Food List food(s): _____

☐ Medication List medication(s) _____

☐ Bee Sting

☐ Other (list): _____

Reactions: ☐ Mild ☐ Severe **Date of last severe reaction**: _____

☐ Coughing ☐ Hives ☐ Rash

☐ Difficulty breathing ☐ Local Swelling ☐ Wheezing

☐ Generalized swelling ☐ Nausea ☐ Other:

Medications needed <u>IN SCHOOL</u>: ☐ NO ☐ YES List Medication(s): _____

☐ ASTHMA

Triggers: ☐ Exercise ☐ Environmental ☐ Other (list):_____

Symptoms:

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Throat itch, tightness, or soreness

☐ Coughing ☐ Hoarseness ☐ Wheezing

☐ Other: _____

Medications needed <u>IN SCHOOL</u>: ☐ NO ☐ YES List Medication(s) _____

Student Name: _____

☐ DIABETES

Currently prescribed medications and treatments:

☐ Insulin ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing ☐ Carbohydrate Counting

☐ Glucagon

☐ Oral Medication(s) List medication(s): _____

Date of last hospitalization related to Diabetes: _____

Is special scheduling of lunch or Physical Education required? ☐ NO ☐ YES

☐ SEZIURE DISORDER

Type of seizure

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-clonic (grand mal, convulsive)

☐ Other (explain): _____

Physical education restrictions? ☐ NO ☐ YES

Date of last seizure: _____ Length of seizure: _____

Currently prescribed medications: _____

Medications needed <u>IN SCHOOL</u>: ☐ NO ☐ YES List Medication(s): _____

☐ OTHER HEALTH CONDITIONS

☐ Cancer ☐ Hemophilia ☐ Sickle cell anemia

☐ ADHD ☐ Other: _____

☐ Heart Condition (be specific): _____

☐ Gastrointestinal Condition (be specific): _____

☐ Physical Disability (be specific): _____

Medications needed <u>IN SCHOOL</u>: ☐ NO ☐ YES List Medication(s): _____

Special procedures (e.g. catheterization, cardiac monitor, etc.) required <u>IN SCHOOL</u>: ☐ NO ☐ YES

(explain): _____

☐ VISION CONDITIONS

☐ Contacts ☐ Glasses

☐ Other: _____

☐ HEARING CONDITIONS

☐ Hearing aid(s)

☐ Other: _____

☐ PHYSICAL RESTRICTIONS

Does your child's health condition restrict participation in Physical Education? ☐ NO ☐ YES

(explain): _____

RETURN COMPLETED FORM TO SCHOOL AS SOON AS POSSIBLE