Orrick R-XI School District
Student Health Form

Name: _____ School Year: _____

Medical diagnosis and/or procedures: ☐ No ☐ Yes

If yes, please explain:

_____

_____

_____

Prescription medication administration at school: ☐ No ☐ Yes

Medication	Dose	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization for over-the-counter medication administration at school (given as needed per label instructions and provided by a parent or guardian): ☐ No ☐ Yes

If yes, please list:

_____

_____

_____

Student has had a physical exam in the last 12 months: ☐ No ☐ Yes

Student has had a dental exam in the last 12 months: ☐ No ☐ Yes

Student has health insurance: ☐ No ☐ Yes

In the event of an emergency and a parent/guardian cannot be reached, the student should be taken for treatment to (hospital):_____

I verify that the information provided on this form is accurate, and I give consent for the district to take action necessary to maintain my student's health.

_____ _____ _____

Signature of Parent/Guardian Print Name Date