HEALTH OFFICE INFORMATION FORM

2024 - 2025

Student Name:_____Date of Birth: _____ Grade:_____

Parent Name:_____ Cell phone: _____

Allergies (food, medication,etc.): _____

Current Medication(s): _____

Health concerns we should be aware of:_____

_____

_____

Vision problems: _____Hearing problems: _____

How will your child react if they are injured or ill? _____

_____

Physician:_____Phone number: _____

Hospital preference: _____

THE FOLLOWING ITEMS ARE AVAILABLE IN THE HEALTH OFFICE FOR USE IN THE EVENT OF ILLNESS OR INJURY. PLEASE CHECK THE BOX FOR EACH ITEM WE MAY USE FOR YOUR CHILD: *Please note: if your child will need allergy medication or antacids during the school day you will need to fill out a medication form and bring in your own supply.*

☐ Ibuprofin (Advil, Motrin)	☐ Acetaminophen (Tylenol)	☐ Cough drops
☐ First Aid Wash	☐ Hydrocortisone 1% lotion	☐ Antacids (Tums)
☐ Bacitracin ointment	☐ Benadryl	☐ Sterile Eye Wash

Child's Weight_____ Dosage: ☐ Give dosage recommended for weight

☐ Other_____

I GIVE PERMISSION FOR THE ABOVE CHECKED ITEMS TO BE USED IF NECESSARY

Parent Signature_____ _____**Date**_____