

NDP HEALTH OFFICE INFORMATION FORM

2026 – 2027

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 CHECKMARK FOR EACH ITEM WE MAY ADMINISTER TO YOUR CHILD: *Please note: If your child needs allergy medication or antacids during the school day, you will need to fill out a medication form and bring in your own supply.*

☐ Ibuprofen (Advil, Motrin)

☐ Acetaminophen (Tylenol)

☐ Cough Drops

☐ First Aid Wash

☐ Hydrocortisone 1% Lotion

☐ Antacids (Tums)

☐ Bacitracin Ointment

☐ Benadryl

☐ Sterile Eye Wash

Childs Weight: _____ lbs.

Dosage: ☐ Give dosage for recommended weight

☐ Other _____

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

Parent Signature: _____ Date: _____