



Medical History/Consent Form

5-404

School Year: _____ School: _____

Emergency Information

Student name: _____		DOB: _____	Grade: _____	ID# _____
Parent Name: _____			Ph#: _____	
Ph#2: _____	Email _____			
Emergency Contact #1: _____		Ph#: _____		
Emergency Contact #2: _____		Ph#: _____		
Doctor Name: _____		Ph# _____		
I _____ authorize the school nurse to contact my child's healthcare provider to discuss any medical-related conditions I may indicate on this form.				

Health History

- Please "check (✓)" any of the following Health Conditions if it pertains to your child:

<input type="checkbox"/> Autism	<input type="checkbox"/> Asthma inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Migraines/ Frequent Headaches
<input type="checkbox"/> ADHD/ ADD	<input type="checkbox"/> Depression/ Anxiety	<input type="checkbox"/> Concussion/Traumatic Brain Injury (within a year)
<input type="checkbox"/> Wear Glasses or Contacts	<input type="checkbox"/> Seizures: Rescue Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies & Reactions: EpiPen: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hearing Loss: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Had Chronic Illness Form for previous school year	<input type="checkbox"/> Diabetes: Type I or Type 2 Continuous Glucose Monitor: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Daily Medications Please List:	<input type="checkbox"/> Other Recent Chronic Illness, Medical Condition, or Surgery Please List:	<input type="checkbox"/> Special Dietary Accommodation: Please List:

Over The Counter (OTC) medication

- At the RN's discretion and following district policy, OTC medication may be administered to treat your child. Please **check Yes or No** for the following:

<input type="checkbox"/> Y	<input type="checkbox"/> N	Ibuprofen (Advil, Motrin)
<input type="checkbox"/> Y	<input type="checkbox"/> N	Acetaminophen (Tylenol)

<input type="checkbox"/> Y	<input type="checkbox"/> N	Antibiotic Ointment
<input type="checkbox"/> Y	<input type="checkbox"/> N	Benadryl Oral/ Benadryl Cream

*Additional OTC medication may also be administered, such as antacid, cough drops, Orajel, and eye drops.

Parent/Guardian Signature _____ Date: _____

❖ Nurse Notes: