

Oak Park Unified School District
Student Daily Health Information and Medical History 2026-2027 School Year

Student Last Name	First Name	Middle Name	M/F/O	Grade
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☐ No medical history to report

Current Medical Conditions: please check if your student currently has any of the following conditions:

☐ Diabetes	☐ Seizure Disorder	☐ Heart Condition	☐ Intestinal Problem
☐ Headache/Migraine	☐ Glasses/Contacts	☐ Kidney Problem	☐ Hearing Aid

Asthma: Please select one of the following: (Additional forms may be required).

☐ Please have your medical provider complete the following and return: ☐ Asthma action plan and ☐ Medication authorization form	☐ No medications are required at school ☐ History of asthma but no longer requires medications or an action plan
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Allergies: Please specify the type of allergies your student has. Additional forms may be required.

☐ Food (Specify)	☐ Insect stings/bites	☐ Other	What type of reaction does your student have?
☐ Please have your medical provider complete the following and return: allergy action plan and Medication authorization form			☐ No medications are required at school
			☐ History of allergies but no longer requires medications or an action plan

If a student has allergies or needs special meal accommodation, please complete the Medical Statement to Request Special Meals form and email schoolmeals@opusd.org

☐ Please share any other medical conditions, treatments required, and any other pertinent information to help us understand your student's current medical condition(s):	
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Medications:

Students may not carry medication, including over-the-counter medication, on their person at school. However, there are 3 medications that a student can keep in their backpack for emergency purposes only (diabetic supplies, inhalers, and Epi-pens). If your student needs to take medication during school or carry emergency supplies an [Authorization For Medications Taken During School Hours](#) form needs to be completed: The form must be completed and signed by the student's physician before the medication can be dispensed and must be renewed yearly.

- ☐ Are medications (prescription or over-the-counter medications) required to be taken while at school? If yes, please complete this: [Authorization For Medications Taken During School Hours](#)
- ☐ No medications are required during school hours for the above conditions

The above information is complete, true and correct. I understand this student health inventory is confidential and will only be shared with designated staff on a "need to know" basis to ensure my child's health and safety at school. I also understand this information will become a part of my child's permanent school health record. If my child requires medications in the original or properly pharmacy-labeled container at school, I will complete an authorization form at the beginning of each school year as needed throughout the year. I also agree to alert the school health office personnel if there is any change in my child's health status during the school year.

 _____ Date: _____

Please type the parent/guardian's full name to authenticate the information provided