

Student's Last Name:	First Name:	Middle Name:	Grade:	Sex:	Age:	DOB:	ID#:
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Parent/Guardian gives permission to receive these at school:

Tylenol (650 mg)	Yes	No	Cough Drops	Yes	No	Anti-itch Ointment/Lotion	Yes	No
Ibuprofen (400 mg)	Yes	No	Antacid (1000 mg)	Yes	No	Antibacterial Ointment	Yes	No
Emergency Benadryl (25 mg)	Yes	No	Throat Spray	Yes	No	Anbesol	Yes	No

Over-the-counter medications may be administered up to one hour before dismissal to ensure that no allergic reaction takes place.**Medical Conditions**

Condition	Yes	No	Explain	Condition	Yes	No	Explain
Allergy (Medication)				Hearing (Loss)			
Allergy (Food)				Heart			
Allergy (Seasonal)				Hepatic & Biliary (Hepatitis)			
Anorexia/Bulimia				Hypertension			
Anxiety				Integumentary (Skin)			
Arthritis/Rheumatic Disease				Malignancies (Cancer)			
Asthma (Carry Inhaler)				Neuro (Migraine Headaches)			
ADD/ADHD				Orthopedic			
Autism, Childhood				Pregnancy			
Birth Defects/Developmental				Psychiatric-Depression, Bipolar			
Bleeding Disorders				Scoliosis			
Coccidioidomycosis-Valley Fever				Seizures Disorder			
Connective Tissue Disorder				Sickle Cell			
Diabetes				Tuberculosis			
Endocrine Disorders				Varicella (Had Chicken Pox)			
Genitourinary (Kidney, Urinary)				Vision (Glasses, Contact lenses)			
Gastrointestinal (Stomach)							
Gynecological							

Other Conditions**Medications**

Physician: _____ Phone: _____ Hospital Preference: _____

I understand that Agua Fria Union HS District #216 does not provide accident medical/dental coverage for students for injuries/illness occurring at school.

Initial at all X's

I understand that if my child needs medication or other health services at school, I must make arrangements with the school health office.

X _____

X _____

I understand that I am financially responsible for any medical, dental, ambulance, or other health care expenses or transportation of my child home, which might occur as a result of such illness or injury.

I understand that it is my responsibility to notify the school in writing of any changes to the above information.

X _____

X _____

If student is unable to remain at school, the parent/guardian will pick up the student or gives the school permission to release the student to the emergency contact. If parent/guardian cannot be reached, authorization is hereby given to any hospital or medical professional to render immediate aid as might be required at the time for the student's health and safety. It is understood the expense of this service would be accepted by the parent/guardian

Parent/Guardian Name (PRINT): _____ Parent/Guardian Signature: _____ Phone: _____ Date: _____