St. Joseph Grade School District #169
Student Health Information

Student Name_____Grade_____Date_____

Physician's Name_____Parent/Guardian Name_____

Please provide the health information requested below. If you have any specific issues or concerns about your child's health, contact the school nurse. **Please see nurse for * areas checked yes.**

Health Concerns

*ALLERGIES Yes_____ No_____
Please list_____

*SEIZURES Yes_____ No_____

*HEART CONDITION Yes_____ No_____

*ASTHMA Yes_____ No_____

*DIABETES Yes_____ No_____

*BLOOD DISORDERS Yes_____ No_____

OTHER HEALTH CONCERNS (Include ADD/ADHD, depression, bipolar disorders, orthopedic conditions,
etc.)_____
_____
_____

Medicine taken at home: _____

I DO_____DO NOT_____(check one) AUTHORIZE THE SCHOOL NURSE TO ADMINISTER GENERIC TYLENOL TO MY CHILD WHEN NEEDED, DOSE APPROPRIATE FOR WEIGHT AND AGE. I ALSO AGREE TO THE ADMINISTRATION OF IBUPROPHEN FOR MENTRUAL CRAMPS FOR GIRLS AGE 12 AND UP.

I DO_____DO NOT_____ AUTHORIZE THE SCHOOL NURSE TO ADMINISTER FIRST AID FOR ANY MINOR INJURY OR COMPLAINT THAT IS DEEMED NECESSARY. SOME PRODUCTS THAT MAY BE USED INCLUDE: caladryl lotion, Anbesol, antibiotic cream, hydrogen peroxide and cough drops.

I understand that health information may be shared with my child's teacher.

Parent/Guardian Signature_____Date:_____