

Student Name: _____
First, Last

Gender _____ Date of Birth _____ Grade _____ Room _____

- | | Yes | No |
|------------------------------|--------------------------|--------------------------|
| 1. Life Threatening Allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Allergy to Bee Sting | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Epilepsy/Seizure | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Heart Disorders/Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Skin Disorders/Eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Migraine Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Fractures/Bone Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Recurrent Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---------------------------------------|--------------------------|--------------------------|
| 11. Head injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Glasses/contacts | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Braces/retainers | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Hearing aids | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Please explain "yes" below | | |

Please check Yes/No next to each over-the-counter medication your child is permitted to take:		
	Yes	No
1. Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>
2. Ibuprofen (Motrin)	<input type="checkbox"/>	<input type="checkbox"/>
3. Antacids (child strength)	<input type="checkbox"/>	<input type="checkbox"/>
4. External ointments, sprays	<input type="checkbox"/>	<input type="checkbox"/>
5. Cough drops/lozenges	<input type="checkbox"/>	<input type="checkbox"/>
6. Sterile eye drops	<input type="checkbox"/>	<input type="checkbox"/>
7. Wound washes	<input type="checkbox"/>	<input type="checkbox"/>
<i>You will be notified when med given at school</i>		

Please explain any "yes" answers, noting question number _____

Food/Drug Allergies: _____

Medications currently being taken: (for more medications, attach additional sheet)

Med#1: _____ Dose/Time taken each day: _____ Reason for taking: _____

Med#2: _____ Dose/Time taken each day: _____ Reason for taking: _____

Student Name: _____
First, Last

Gender _____ Date of Birth _____ Grade _____ Room _____

- | | Yes | No |
|------------------------------|--------------------------|--------------------------|
| 17. Life Threatening Allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Allergy to Bee Sting | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Epilepsy/Seizure | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Heart Disorders/Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Skin Disorders/Eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Migraine Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Fractures/Bone Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Recurrent Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---------------------------------------|--------------------------|--------------------------|
| 27. Head injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Glasses/contacts | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Braces/retainers | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Hearing aids | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Please explain "yes" below | | |

Please check Yes/No next to each over-the-counter medication your child is permitted to take:		
	Yes	No
1. Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>
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