# HEALTH INFORMATION FORM

This form must be filled out completely and be submitted to the homeroom teacher at the beginning of school year. Please circle the appropriate responses. You may elaborate as needed on the back side of this form.

Student name _____ Grade _____

Does your child have health insurance? YES NO If yes, name of insurance provider:

_____

Name and # of physician that cares for this child_____

_____

Does your child have any known FOOD allergies? Yes No If yes, list: _____

Does your child require the use of an EPI PEN for this/these allergies? Yes No If yes, you are REQUIRED to produce the doctor's order and an epi pen to the nurse. If these are not handed in in a timely fashion, the student's name will be submitted to the Principal for consideration regarding attendance at the school.

Does your child take any medications? Yes No If yes, please list_____

Does your child require this medicine to be administered during school hours? Yes No If yes, you must obtain a doctor's order, provide a parental consent and bring the medicine to school in the original pharmacy container.

Has your child ever had surgery? Yes No If yes, please list _____

Is your child being treated for ADD/ADHD? Yes No name medicine _____

Is your child being treated for or have a history of depression, anxiety or other emotional condition? Yes No If yes, please explain. _____

Does your child have any medical conditions or physical limitiations? Yes No If yes, please list/explain_____

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Does your child have any visual or hearing impairments that require special seating? Yes No

Is there anyone restricted from picking up your child? Yes No If yes, please list name(s) and relationship(s)

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By signing below, I attest that I have given complete information regarding my child's health. In addition, I give permission for the school nurse to share pertinent medical information with the school staff and to contact and share information with my child's physician as needed. I also give consent, in the event of serious illness or accident, for the Bishop Feehan High School designee to call emergency medical services and transport my child as necessary to the nearest medical facility.

Parent/guardian signature _____ Date _____

# OVER-THE-COUNTER MEDICATION CONSENT

As the school nurse it is my goal to assist every student to optimum health so that he/she may attend classes and participate in their own education. While every attempt is made to avoid giving medication in school, there are times when a mild pain reliever or other over-the-counter medicine is appropriate. If you would like your child to be allowed (after being assessed by the nurse) to receive any of the following medicines as directed on the package, please sign below. If your child requires a different type of medicine such as Excedrin, Aleve etc. You will need to submit MD documentation and the medicine.

Ibuprofen (Advil, Motrin) Acetaminophen (Tylenol) Tums (these are on hand in the nurse's office.)

Parent/guardian signature _____ Date _____