RESET

St. David Unified School District

Where Students Are Our Primary Focus

ANNUAL STUDENT MEDICAL INFORMATION

All students must have completed form on file every year. Information will be stored in Student Health Records and will be confidential to the greatest extent allowable by law.

Last Name First Name Date of Birth Grade

Does your child have any medication or food ALLERGIES? Please list allergies and reactions:

_____

Does your child have any of the following conditions? (Check all that apply and describe below.)

☐Yes	☐No	Asthma	☐Yes	☐No	Headaches/Migraines
☐Yes	☐No	Dental Problems	☐Yes	☐No	Emotional Problems
☐Yes	☐No	Skin Conditions	☐Yes	☐No	ADHD
☐Yes	☐No	Gastrointestinal Disorder	☐Yes	☐No	Vision problems
☐Yes	☐No	Diabetes	☐Yes	☐No	Hearing problems
☐Yes	☐No	Seizure Disorder	☐Yes	☐No	Uses assistive devices
☐Yes	☐No	Heart Condition	☐Yes	☐No	Other:_____
☐Yes	☐No	Kidney Disease			

Please describe: _____

Does your child take medication regularly? Please list: _____

MEDICATION POLICY

All medications must be brought in original containers. Written parental permission must accompany all medicine, regardless if it is prescription or non-prescription. Order from the physician must accompany prescribed medication. (Printed prescription on medication bottle will be accepted for order from doctor for prescription medication.) Use of the following medications: TYLENOL, IBUPROFEN, BENADRYL, DECONGESTANT (PHENYLPHRINE), BLISTEX, AMBESOL, TUMS, SORE THROAT SPRAY, HYDROCORTISONE CREAM, (anti-itch cream), TOPICAL ANTIBIOTICS, BURN GEL, EYE DROPS (Artificial Tears), COUGH DROPS/LOZENGES will be at the discretion of the District Nurse or personnel designated by the Principal. Regular use of these and any other non-prescription medications will require written physician's orders and are to be supplied by the parent/guardian.

Please CHECK the BOX then INITIAL BELOW:

❑ I DO_____ (initial)	❑ I DO NOT _____ (initial)	Give my permission for the District Nurse or other personnel designated by the Principal to administer the above medications to my child.
❑ I DO _____ (initial)	❑ I DO NOT _____ (initial)	Understand that any request for regular administration of prescription and non-prescription medication will require parental and physician permission and must be supplied by the parent.

Your signature below indicates that this permission form will be in force until you notify the office **in writing**. Additionally**, it is your responsibility to notify the office if any medical information on this form changes.**

SIGNATURE: _____ DATE:_____