

Student Name _____

Grade _____

Permission for Non-Prescription Medications

In order to administer non-prescription medicine to a student, Indiana law requires that written parent permission be on file with the school. When students request non-prescription medicine, much time is spent contacting the parent. To make this procedure more convenient for parents and the principle (or her designee) the following check list and consent form are being provided for your signature.

Please check the non-prescription medicines that may be given to your son/daughter by the school nurse or other appointed school personnel. If a non-prescription medicine is not included on the list, please add it on the blank provided.

Parent Signature _____

Tylenol (extra strength) Midol (generic menstrual relief)

Ibuprofen Cough drops

Benadryl (allergies/itching) Tums (generic antacid)

Tylenol cold (Tylenol with decongestant)

Other _____

Brief Student Medical History

Asthma Uses Inhaler? Yes No

Seizures

Bee Sting Allergy Uses Epi-Pen? Yes No

Seasonal Allergies

Food Allergies

Diabetic

Meds taken on a regular basis/ Other Information

ATTENTION: NURSE

Health Questionnaire
(Parent/Guardian need to complete)
Please Print!

Student: _____ Date of Birth: ____/____/____

Address: _____

City: _____ Zip _____ Phone Number: _____

School: _____ Entering Grade: _____

Father's Name: _____ Mother's Name: _____

Student Lives With: _____

Disease/Condition	Yes (List month/year)	No	Disease/Condition	Yes List month/year	No
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Scarlet Fever		
Measles			Other		

Has your child had an infectious/communicable disease other than those listed above? Please explain giving relevant dates: _____

Please list any of the following with the month/year:

Operations: _____

Illnesses (Eye, ear, heart, stomach, kidney): _____

Severe Injuries (Head Injury, Fractures, etc.): _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment? _____

Please list any condition that should be considered in planning your child's school day:

Allergies/Reactions: _____

Physician Name: _____ Phone #: _____

Dentist Name: _____ Phone #: _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent Signature _____ Date _____