**MEDICAL INFORMATION/RELEASE FORM**
**Return to Health Office**

***** THIS FORM MUST BE SIGNED and DATED *****

**THIS FORM IS IMPORTANT IN THE CARE OF YOUR STUDENT WHILE AT SCHOOL, and IF YOUR CHILD SHOULD NEED IMMEDIATE EMERGENCY CARE, IT WOULD BE NECESSARY FOR THE HEALTH OFFICE TO HAVE THIS INFORMATION AVAILABLE IMMEDIATELY. PLEASE REMEMBER TO PROVIDE UPDATED INFORMATION TO THE NURSE WHEN HEALTH CHANGES OCCUR AND UPDATED INFORMATION TO THE SCHOOL OFFICE WHEN CONTACT INFORMATION CHANGES.**

**IF NEITHER PARENT/GUARDIAN CAN BE CONTACTED, I AUTHORIZE THE SCHOOL ADMINISTRATION TO TAKE SUCH EMERGENCY ACTION AS NEEDED.**

**DATE:** _____ **SIGNATURE OF PARENT/GUARDIAN:** _____

**PRINTED NAME OF PARENT/GUARDIAN:** _____ **PHONE:** _____

**STUDENT NAME:** _____ **DOB:** _____ **GENDER:** ____ **SCHOOL:** _____ **GRADE:** ____

**HEALTH/MEDICAL INFORMATION:**

Any known health conditions (please be specific): _____

_____

Current treatment: _____

Any illnesses, injuries, or surgery within this last year: YES NO (If yes, please explain.) _____

_____

Does your child need an asthma inhaler during the school day or for sports? YES NO

(If yes, please note any restrictions, include a copy of the emergency plan, and complete the medication authorization form. This form must be completed by both physician and parent._____)

Does your child have any vision or hearing difficulties? If yes, please specify: _____

Please circle corrective devices your child may need at school: Glasses Contacts Hearing aid Orthopedic aides
Other: _____

Is there anything about your child's health (physical or emotional) that you would like the teacher or nurse to know? If yes, please specify: _____

_____

**ALLERGIES:**

Insects/Bees: Localized: YES NO Severe: YES NO Epi-Pen required? YES NO Benadryl required? YES NO

Foods (please list): _____ Epi-Pen required? YES NO Benadryl required? YES NO

(If yes, please note any restrictions, include a copy of the emergency plan, and complete the medication authorization form. This form must be completed by both physician and parent. _____)

Medication allergies (please list): _____

**MEDICATIONS:**

Medication taken at HOME on a regular basis:

Medication name: _____ Dose: _____ Frequency: _____ Reason: _____
Medication name: _____ Dose: _____ Frequency: _____ Reason: _____
Medication name: _____ Dose: _____ Frequency: _____ Reason: _____

Medication needed at SCHOOL on a regular basis:

Medication name: _____ Dose: _____ Frequency: _____ Reason: _____
Medication name: _____ Dose: _____ Frequency: _____ Reason: _____
Medication name: _____ Dose: _____ Frequency: _____ Reason: _____