STUDENT NAME_____GRADE_____

A student's health record is of vital importance. The health information you provide enables the district staff to give safe and optimal learning experiences. While you may refuse to provide health information, such a refusal may adversely affect the learning process and your child's safety. For these reasons, we encourage you to keep the health staff informed of your child's health status.

HEALTH CONDITIONS: Please note any health conditions your child currently experiences:

☐ asthma– if checked, does your child need an inhaler while at school? ☐Yes ☐No
If yes, would you like student to carry it him/herself or keep it in the health office? ☐self-carry ☐keep in health office

☐allergies– if checked, please specify_____
Usual treatment requirement: ☐EpiPen ☐anti-histamine (Benedryl) ☐ other (please specify)_____

☐seizures—if checked, what is the date of student's last seizure? _____ Please describe type and frequency of seizures _____

☐headaches ☐ADHD ☐ anxiety ☐depression ☐hearing problems ☐vision problems

☐other health issues_____

MEDICATIONS: Please list all medications student takes. If student requires medication at school, please complete separate medication administration form.

Drug name	purpose	amount/dosage	time given
Drug name	purpose	amount/dosage	time given
Drug name	purpose	amount/dosage	time given

☐ **I give my child's medical provider and Rush City Public Schools permission to release and obtain information from each other as necessary. This authorization takes effect the day I sign it and expires one year from the date of my signature. I understand I may change this authorization at any time.**

_____
Parent/Guardian Signature Date

DENTIST_____
Name/phone number

MEDICAL PROVIDER/CLINIC_____
Name/phone number

Please inform my child's teacher and other appropriate staff of his/her health concerns as necessary. ☐Yes ☐No

PLEASE COMPLETE THE REMAINDER OF THIS FORM FOR STUDENTS IN GRADES 7-12 ONLY.

High school students are allowed to self-administer over-the-counter pain relievers (acetaminophen, ibuprofen, naproxen) with the authorization of a parent or guardian. This privilege may be revoked at any time at the discretion of school staff. Medications containing ephedrine or pseudoephedrine (Sudafed) may NOT be self-administered at school.

I request that my child be allowed to self-administer appropriate over-the-counter medications. My child has agreed to use the correct dosage schedule and will not share it with anyone else. He/she will notify the school nurse or other appropriate staff if pain persists or side effects occur. Failure to comply will result in revocation of this privilege.

_____
Parent/Guardian Signature Date

_____
Student Signature Date