SOUTH TECHNICAL HIGH SCHOOL – 2017-2018

STUDENT MEDICAL INFORMATION

STUDENT INFORMATION – (PLEASE PRINT)						
Student's Last Name:	**Student's First Name:**	**Middle Name:**	**Birth Date:**	**Age:**	**Sex:**	
			/ /		❑ M	❑ F

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)			
#1 Contact Name:	Home Phone #:	Cell Phone #:	Employer Phone #:
	( )	( )	( )
Relationship to Student:			
#2 Contact Name:	Home Phone #:	Cell Phone #:	Employer Phone #:
	( )	( )	( )
Relationship to Student:			

In a **medical emergency**, the following person(s) has authorization to release this student from school, **when a parent/guardian cannot be located**:

Name of local friend or relative:	Relationship to Student:	Phone #:	Work #:
		( )	( )
Name of local friend or relative:	Relationship to Student:	Phone #:	Work #:
		( )	( )

In case of illness or injury requiring emergency medical care, you have my permission to obtain such care from the nearest hospital, and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.

Preferred Hospital:	Primary Care Physician Name:	Physician Phone #:
		( )

MEDICAL HISTORY – (PLEASE PRINT)

Does this student have a history of any of the following conditions:

Condition		
Asthma?	❑ Yes	❑ No
Diabetes?	❑ Yes	❑ No
Heart Condition?	❑ Yes	❑ No
Convulsive Disorder?	❑ Yes	❑ No
Hearing Loss?	❑ Yes	❑ No
Wear Hearing Aid?	❑ Yes	❑ No
High Blood Pressure?	❑ Yes	❑ No
Wears Glasses/Contacts	❑ Yes	❑ No

Taking Other Medications?

If Yes, Please List:	Amount Taken:	Time(s) Taken:

Allergies?	❑ Yes	❑ No	**Please List:**
Epi-Pen?	❑ Yes	❑ No	
Other Medical Conditions?	❑ Yes	❑ No	**Please List:**

The above information is true to the best of my knowledge. I understand that it is the responsibility of the parent/guardian to inform the school of any changes.

Parent/Guardian Signature:	*Date:*

PLEASE READ AND COMPLETE BOTH SIDES OF THIS FORM

SOUTH TECHNICAL HIGH SCHOOL – 2017-2018
PARENT/GUARDIAN PERMISSION FOR OVER-THE-COUNTER MEDICATION

Student Name: _____________________________________ D.O.B: _____________________________

Parent/Guardian: ____________________________________ Phone: ____________________________

I give my permission for the Special School District Registered Nurse, or her designee, to administer the following over-the-counter (OTC) medications as ordered by the District's medical consultant to my child for minor complaints. (.e.g. headache, stomach ache, menstrual cramps, minor allergic reactions, and muscle pain). These medications will be administered according to label dosage and manufacturer recommendations.

1. These medications will be used for first aid and acute care only. Students requiring daily or frequent use will be required to submit an order from their private physician.
2. Only one dose of an OTC medication will be administered during a school day. If symptoms are not relieved, a parent/guardian will be notified.
3. The nurse will notify a parent/guardian in advance, when possible, that medication is to be given, so parents are aware of the child's complaint.
4. Students may not to carry medication on their person.
5. The nurse reserves the right to deny these medications if, in her professional judgment, it would be detrimental to the child's health or safety.

Please list any known drug allergies: ____

Please circle any medications we MAY give your child, on an "as needed" basis:

Benadryl	YES	NO	Mentholyptus throat lozenges	YES	NO
Tums antacid	YES	NO	Ibuprofen (pain relief)	YES	NO
Acetaminophen (Tylenol)	YES	NO	Buffered eye Wash (minor)	YES	NO
Sting Kill wipes (insect)	YES	NO	Hydrogen peroxide (minor)	YES	NO

Parent/Guardian Signature ________________________________ Date___________________________

PLEASE READ AND COMPLETE BOTH SIDES OF THIS FORM