# Confidential Student Medical Form

**The following information will be kept in the Nurse's Office**

Student Last: _____ Student First: _____ Student Middle_____
Address: _____ Town: _____ Zip: _____

Student Phone Number _____ Date of Birth: _____/_____/_____ Grade: _____

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**In case of emergency we will attempt to contact parent/guardian before calling student's primary care provider. Your child will be transported by ambulance to an emergency care facility if necessary.**

Physician's Name: _____ Physician's Telephone: _____

Dentist's Name: _____ Dentist's Telephone: _____

Preferred Hospital Name: _____ Location: _____
Name of Insurance Carrier_____

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Please list medications your child regularly takes at home or school_____

_____

Please check all that apply to your child:
□ Severe Allergy requiring EpiPen – Please specify _____
□ Other allergies - Please specify_____ □ Asthma □ Diabetes □ Seizures □ Migraines □ ADD/ADHD □ Autism □ Anxiety □ Depression □ Heart condition □ Hearing problems □ Hearing aids □ Vision problems □ Glasses □ Contacts □ Other health condition- Please specify_____

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●I give permission for the School Nurse to administer the following medication to my child per School Physician Standing Orders:

**Please review the following list and cross out any medication you do **NOT** want your child to receive.**

- Acetaminophen (Tylenol)
- Ibuprofen (Motrin, Advil)
- Diphenhydramine (Benadryl)-generalized allergic reaction
- Chewable antacid (Tums/Rolaids)
- Cough drops with menthol/sugar free (may be crushed)

●I give permission for the school nurse to share information relevant to my child's health condition with appropriate school and/or emergency medical personnel when needed to meet my child's health and safety needs. I give permission for the nurse to exchange information with my child's primary care provider for the purpose of referral, diagnosis and treatment.

●I give permission for my child to be treated and transported by emergency medical personnel to an emergency care facility if necessary. In case of emergency the school will attempt to contact parent/guardian and/or student's primary care physician.

Parent/Guardian Signature _____ Date: _____