

## Student Health & Medical Concerns Sheet 2023-2024

**Welcome to a new school year.** To make sure your child receives the best medical care possible during the school year, we must be aware of all medical conditions and can reach you in case of an emergency. Please complete the form below. All **NEW STUDENTS** must have a recent physical and dental record on file and **ALL STUDENTS** must be up to date with immunizations by the first day of school.

Student's Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent Contact #1: Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone#: \_\_\_\_\_

Parent Contact #2: Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone#: \_\_\_\_\_

Alternate Contact #3 Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Phone #: \_\_\_\_\_

1. Does your child have any **medical, behavioral or social conditions**? If so, please list.

\_\_\_\_\_

2. Does your child take any **prescription or over-the-counter medications**? If so, please list. (Attach Med-1 Form if needed at school)

\_\_\_\_\_

3. Does your child have any **food, insect, or environmental allergies**? Please identify the allergy, what reactions occur, and the necessary treatment. \_\_\_\_\_

\_\_\_\_\_

4. Does your child require any **accommodations for gym class**? (If yes please attach the MEH-23 paperwork from health care provider ).

\_\_\_\_\_

5. Does your child have an **IEP or 504 Plan**?

\_\_\_\_\_

6. Does your child wear **eyeglasses or contact lenses**? \_\_\_\_\_ Yes \_\_\_\_\_ No

7. Do you need assistance getting **health insurance** for your child? \_\_\_\_\_ Yes \_\_\_\_\_ No

8. Is there a need for you or your child to have a **conference with the school nurse**? \_\_\_\_\_ Yes \_\_\_\_\_ No

9. Please check (✓) the following oral/topical medications we have your permission to administer:

\_\_\_\_ Tylenol/Acetaminophen \_\_\_\_ Motrin/Ibuprofen \_\_\_\_ Benadryl (*for serious allergic reactions only*)

\_\_\_\_ Benadryl Cream \_\_\_\_ Caladryl \_\_\_\_ Calamine Lotion \_\_\_\_ Neosporin \_\_\_\_ Anbesol/Orajel

\_\_\_\_ Hydrocortisone Cream 1% \_\_\_\_ Visine drops \_\_\_\_ Chloraseptic Spray \_\_\_\_ Throat Lozenges (*grades 4-12 only*)

**I AUTHORIZE THE SCHOOL NURSE TO SHARE THIS INFORMATION WITH SCHOOL STAFF AS NECESSARY.**

\_\_\_\_\_  
PRINT Parent/Guardian SIGNATURE Parent/Legal Guardian

\_\_\_\_\_  
DATE