HEALTH INFORMATION/MEDICATION PERMISSION

Student Name_____ Date of birth_____ Grade_____

Please check any medical condition(s) that apply to your student.

- ☐ No known health concerns
- ☐ ADD/ADHD (**Please circle one**)
- ☐ Asthma (**If you checked this box, please fill out the back of this form**)
- ☐ Allergies
  - Bee sting _____ **(Requires EpiPen? Y N)**
  - Food _____ **(Requires EpiPen? Y N)**
  - Medication _____ **(Requires EpiPen? Y N)**
  - Other _____ **(Requires EpiPen? Y N)**
- ☐ Other medical condition(s)_____

_____

Please list any physical restrictions.

_____

Please list **ANY** medication(s) taken **at home or school** (name/dose/frequency).

_____

_____

_____

I give the school permission to give my student the following medications (as needed):

- ☐ Acetaminophen
- ☐ Antacid
- ☐ Ibuprofen
- ☐ Benadryl

- ❖ All other over-the-counter medication must be brought to school in its original (sealed) container and accompanied by a parent/guardian permission note.
- ❖ Prescription medications that must be given at school need to be delivered to the Health Office by the parent/guardian and accompanied by a physician's prescription.
- ❖ If you have questions – please contact the health office at (507) 663-0634.

PARENT/GUARDIAN SIGNATURE _____DATE_____

EMAIL _____

DAYTIME CONTACT NUMBER(S)

_____

PHYSICIAN/CLINIC _____ PHONE _____