STUDENT HEALTH INFORMATION

Student Name: **Student DOB: «DOB»**

Student ID#: **Grade/YOG:**

Physician's Name	Phone	Date of Last Physical Exam

Please indicate if your child is receiving treatment for any medical conditions:

Asthma: Yes___ No____	**Inhaler Use: Yes ____ No____	How Often Used:
Allergic to Bee Stings:	Reaction:	Epi Pen: Yes ____ No ____
Allergies (other than above): Y or N	To What:	Epi Pen: Yes ____ No ____
Vision Problems:	Glasses, Contacts, Safety Glasses	Hearing Problems:
Heart Problems:	Seizures:	Orthopedic:

**If an inhaler is required for school use, the WPS Authorization for Medication to be Taken During School Hours form is REQUIRED to be completed by your Physician.

Describe any conditions and present treatment, including medications, restrictions, etc., that your child may be experiencing: _____

IBUPROFEN/TYLENOL/BENADRYL AUTHORIZATION

(Please read below carefully and sign the appropriate section/s)

Grades 5-12

I give permission for the School Nurse to administer **Tylenol (325mg 1 or 2) or Ibuprofen (200mg 1 or 2)** to my child in the event they should request it.

Parent/Guardian Signature: _____ Yes____ No____

Grades K-4

I give permission for the School Nurse to administer **Acetaminophen (Tylenol)** for a fever of 101 or greater (dose based on weight)

Parent/Guardian Signature: _____ Yes____ No____

Grades K-12

I give permission for the School Nurse to administer **Benadryl** orally, following standing order protocol, in the event of a mild reaction.

Parent/Guardian Signature: _____ Yes____ No____

Date: _____