STUDENT HEALTH INFORMATION

STUDENT NAME: _____

GRADE: _____ AGE: _____

If student is on any routine medications please list:

_____

_____ Do we need to give it at school? _____

ALLERGIES:

_____

_____

ANY CHRONIC HEALTH PROBLEMS SUCH AS EYESIGHT, HEARING, ASTHMA, DIABETES, ETC:

_____

_____

NAME and PHONE # TO CONTACT IN EMERGENCY, IF PARENT CANNOT BE REACHED:

_____

I hereby grant permission for Banner County School Personnel to dispense non-prescription medication when deemed necessary for the well being of above named child. I grant permission for information regarding allergies, asthma, etc., to be given to teachers. I grant permission in the event that an illness or accident might occur when a parent is not available, for the school to secure medical attention. Any exceptions to this permission? _____

_____

PARENT'S or GUARDIAN'S SIGNATURE

THANK YOU FOR YOUR HELP!
Marie Parker, RN School Nurse