WHITKO COMMUNITY SCHOOL CORPORATION

2019-2020 STUDENT HEALTH HISTORY

NAME_____ SCHOOL _____

DATE OF BIRTH _____ GRADE _____

PARENT OR GUARDIAN _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE_____ DOCTOR NAME _____

HEALTH INFORMATION

Please check any area that applies to your student and explain on the line following.

__**Medically diagnosed** severe life threatening allergy_____

__**Allergy causing ER visits** from insects, plants, or food_____

__**Doctor restricted** foods or diets_____

__Heart **diagnosis**_____

__Respiratory **diagnosis** _____

Other medical conditions that have been **doctor diagnosed**_____

Medications taken at home _____

*******I give permission for this information to be shared with the school staff and emergency medical staff that might have direct contact with my child.

*******I give permission for school staff to care for and to meet the immediate health needs of my child.

***I give permission for school staff to update the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP).

OVER THE COUNTER MEDICATIONS

The following over the counter medications are available at Whitko Community School Health Clinics. I give permission for my child to receive the following over the counter medications if needed. I understand the

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medications will be given in accordance with the manufacturer's label directions. Medications that are crossed off the below list will not be given to your child without permission.

MEDICATION	**TREATMENT**
BENADRYL (Liquid or tabs)	**Allergic Reaction**
TYLENOL (Acetaminophen: generic for Tylenol)	**Pain reliever/fever reducer**
IBUPROFEN – (Liquid or tabs)	**Muscle aches/menstrual cramps**
BACITRACIN OINTMENT – external use for:	**Minor cuts/scrapes**
HYDROCORTISONE CREAM (1% with aloe)	**Pain/itch skin irritations**
CALADRYL LOTION – external use for:	**Pain/itch skin irritations**
INSECT STING SWABS – external use for:	**Pain/itch with insect bites**

Parent/Guardian Signature
_____Date_____

***__OVER THE COUNTER MEDICATION__: Medication sent from home must be in the original container and the label must be intact. **A parent note (given to school/nurse)** must list the student's name, the medication name, and dosage before the medication will be given.

***__PRESCRIPTION MEDICATION must be in the original bottle from the pharmacy__. Ask pharmacist for a separate bottle if to be taken during school hours. The Prescription Label must be in place listing the student's name, medication name, dosage, prescribing doctor and date. **A parent note (given to school/nurse) must contain the SAME information. It is the responsibility of the person bringing in the medication to verify, by signature, how many pills, tabs, or any other measurement of medication that is being turned over to nurse, front office staff or other Whitko Community Schools representative.**

PRESCRIPTION MEDICATIONS TO BE TAKEN AT SCHOOL

1)Medication Name _____Start Date_____

Dosage _____Time to be given_____

Parent/Guardian Signature_____

PRESCRIPTION MEDICATIONS TO BE TAKEN AT SCHOOL

2)Medication Name _____Start Date_____

Dosage _____Time to be given_____

Parent/Guardian Signature_____

PRESCRIPTION MEDICATIONS TO BE TAKEN AT SCHOOL

3)Medication Name _____Start Date_____

Dosage _____Time to be given_____

Parent/Guardian Signature_____

PRESCRIPTION MEDICATIONS TO BE TAKEN AT SCHOOL

4)Medication Name _____Start Date_____

Dosage _____Time to be given_____

Parent/Guardian Signature_____