STUDENT MEDICAL HISTORY AND CONSENT FORM

Student Name _____ Male or Female (circle one) Date of Birth ____/____/_____

Parent/Guardian's Name(s)_____ Grade _____

Address _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact Name_____ Phone _____
(Other than parent/guardian)
Relationship of contact person to the student _____

Physician's Name and Phone Number _____

Dentist's Name and Phone Number _____

Name of Insurance _____ Policy or ID Number _____

Is your child taking **any** medications? YES _____ NO _____

If yes, list the names of medications and name of doctor(s) who prescribed them: _____

_____
(If medications are needed during school hours, please contact the school nurse for additional form)

PAST MEDICAL HISTORY

(Please circle Yes or No)

Asthma	Yes No	Dental Problems	Yes No	Menstrual Disorders	Yes No
Bladder/KidneyProblem	Yes No	Diabetes	Yes No	Mental/Emotional Disorders	Yes No
Bone/Joint Problems	Yes No	Frequent Infections	Yes No	Seizures	Yes No
Bowel Problem	Yes No	Headaches	Yes No	Skin Problem	Yes No
Breathing Problem	Yes No	Hearing (Hearing Aid)	Yes No	Stomach Problem	Yes No
Broken Bones	Yes No	Heart Disease/Murmur	Yes No	Vision (glasses or contacts)	Yes No
Concussion(s)	Yes No				

If yes to any of the above, please explain _____

_____

Please list any surgeries, serious injuries, childhood diseases _____

Allergies _____ Type of Reaction _____
(If an epi-pen is required, please contact the school nurse for additional form)

MAY NOT PICK UP STUDENT: _____

MAY PICK UP STUDENT: (1)_____(2)_____
(In addition to parent/guardian/emergency contact)

I give my consent for my child _____ to be examined by the school nurse at St. Patrick Catholic High School for treatment as required. **YES** _____ **NO** _____

Parent/Guardian Signature _____ Date _____

********PLEASE COMPLETE PAGE 2********

Administration of Over-the-Counter Medications
Permission Form

Below is a list of over-the-counter items that **may** be available in the health office. Medications will be given according to the manufacturer recommended dosage and health office protocols unless otherwise specified by you or your physician.

Please initial next to each medication for which you give your permission for administration to your child. Please note that generic forms of the specific medication may be used.

Oral Medications

___ Acetaminophen/Tylenol
___ Ibuprofen/Advil/Motrin
___ Diphenhydramine/Benadryl
___ Antacid
___ Simethicone/Gas-X
___ Phenylephrine HCL/Sudafed PE
___ Loratadine/Claritin
___ Chloraseptic type throat spray
___ Cough drops/Sore throat lozenges

Topical Medications

___ Triple antibiotic ointment/Neosporin
___ Diphenhydramine/Benadryl ointment
___ Calamine/Caladryl lotion
___ Hydrocortisone ointment
___ Aloe vera or other burn gel
___ Topical analgesic

_____ I **give permission** for my child to be given the over-the-counter medications that are initialed.

_____ I **do not** need to be notified each time my child is given medication.
_____ I **would like** to be notified **each** time my child is given medication.

_____ I **do not give permission** for my child to be given any over-the-counter medications at school.

Parent/Guardian Signature_____ **Date**_____

Physician Signature _____ **Date**_____
(Optional)