

**NORTH TECHNICAL HIGH SCHOOL – 2017-2018  
STUDENT MEDICAL INFORMATION**

**STUDENT INFORMATION – (PLEASE PRINT)**

<b>Student's Last Name:</b>	<b>Student's First Name:</b>	<b>Middle Name:</b>	<b>Birth Date:</b>	<b>Age:</b>	<b>Sex:</b>
			/ /		<input type="checkbox"/> M <input type="checkbox"/> F

**EMERGENCY CONTACT INFORMATION (PLEASE PRINT)**

<b>#1 Contact Name:</b>	<b>Home Phone #:</b>	<b>Cell Phone #:</b>	<b>Employer Phone #:</b>
	( )	( )	( )

Relationship to Student:

<b>#2 Contact Name:</b>	<b>Home Phone #:</b>	<b>Cell Phone #:</b>	<b>Employer Phone #:</b>
	( )	( )	( )

Relationship to Student:

In a **medical emergency**, the following person(s) has authorization to release this student from school, **when a parent/guardian cannot be located**:

<b>Name of local friend or relative:</b>	<b>Relationship to Student:</b>	<b>Phone #:</b>	<b>Work #:</b>
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<b>Name of local friend or relative:</b>	<b>Relationship to Student:</b>	<b>Phone #:</b>	<b>Work #:</b>
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**In case of illness or injury requiring emergency medical care, you have my permission to obtain such care from the nearest hospital, and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.**

<b>Preferred Hospital:</b>	<b>Primary Care Physician Name:</b>	<b>Physician Phone #:</b>
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**MEDICAL HISTORY – (PLEASE PRINT)**

**Does this student have a history of any of the following conditions:**

<b>Asthma?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="1"> <tr> <td colspan="3"><b>Taking Other Medications?</b></td> </tr> <tr> <td><b>If Yes, Please List:</b></td> <td><b>Amount Taken:</b></td> <td><b>Time(s) Taken:</b></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	<b>Taking Other Medications?</b>			<b>If Yes, Please List:</b>	<b>Amount Taken:</b>	<b>Time(s) Taken:</b>																		
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<b>If Yes, Please List:</b>	<b>Amount Taken:</b>		<b>Time(s) Taken:</b>																							
<b>Diabetes?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									
<b>Heart Condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									
<b>Convulsive Disorder?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									
<b>Hearing Loss?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									
<b>Wear Hearing Aid?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									
<b>High Blood Pressure?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									
<b>Wears Glasses/Contacts</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																									

<b>Allergies?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please List:</b>
<b>Epi-Pen?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Other Medical Conditions?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please List:</b>

The above information is true to the best of my knowledge. I understand that it is the responsibility of the parent/guardian to inform the school of any changes.

<i>Parent/Guardian Signature:</i>	<i>Date:</i>
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**PLEASE READ AND COMPLETE BOTH SIDES OF THIS FORM**

**NORTH TECHNICAL HIGH SCHOOL – 2017-2018  
PARENT/GUARDIAN PERMISSION FOR OVER-THE-COUNTER MEDICATION**

Student Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

I give my permission for the Special School District Registered Nurse, or her designee, to administer the following over-the-counter (OTC) medications as ordered by the District’s medical consultant to my child for minor complaints. (.e.g. headache, stomach ache, menstrual cramps, minor allergic reactions, and muscle pain). These medications will be administered according to label dosage and manufacturer recommendations.

1. These medications will be used for first aid and acute care only. Students requiring daily or frequent use will be required to submit an order from their private physician.
2. Only one dose of an OTC medication will be administered during a school day. If symptoms are not relieved, a parent/guardian will be notified.
3. The nurse will notify a parent/guardian in advance, when possible, that medication is to be given, so parents are aware of the child’s complaint.
4. Students may not to carry medication on their person.
5. The nurse reserves the right to deny these medications if, in her professional judgment, it would be detrimental to the child’s health or safety.

Please list any known drug allergies: \_\_\_\_\_

**Please circle any medications we MAY give your child, on an “as needed” basis:**

Benadryl	YES	NO	Mentholypus throat lozenges	YES	NO
Tums antacid	YES	NO	Ibuprofen (pain relief)	YES	NO
Acetaminophen (Tylenol)	YES	NO	Buffered eye Wash (minor)	YES	NO
Sting Kill wipes (insect)	YES	NO	Hydrogen peroxide (minor)	YES	NO

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE READ AND COMPLETE BOTH SIDES OF THIS FORM**