North Dougals Elementary/Middle School 2020-2021

STUDENT MEDICAL HISTORY

Student Name _____ Sex: M___F___Other___ Birthdate_____

Address _____ Phone_____

Parent or Guardian _____

Does your child:

1. Have diabetes? Yes____ No____
2. Wear glasses or contacts? Yes____ No____
3. Have asthma? Yes____ No____
    a. Use inhaler? Yes____ No____
4. Have allergies? Yes____ No____
    a. Allergies to what?_____
    b. Does your child require an Epi Pen? Yes____ No____

Is your child currently taking any medications at home? Yes____ No____
Does your child require prescription medications at school? Yes____ No____

Do you give your permission for NDEMS office employees to give your child a **200/400 (circle one) mg** dose of ibuprofen if needed for aches or pains? **Yes___ No____Cough drops? Yes____ No___**

Does your child have any **physical, behavioral or emotional needs** that might require special attention or consideration at school? Please list:

_____

Signature of Parent/Guardian:_____ Date_____

All medication (both prescription and non-prescription) must be delivered to school by an adult, and must be in the original container. Parent will be asked to complete a permission slip allowing office personnel to administer meds.

To allow your middle school student to "self administer" medication, please pick up a form in the office.