



## Health Office General Information Form

**Student Name:** \_\_\_\_\_ **Teacher/Grade** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

Check yes or no for permission to administer at school. Parent is attempted to be reached before administration.

Medication NAME	YES	NO
Ibuprofen (Advil)		
Acetaminophen (Tylenol)		
Diphenhydramine HCL (Benadryl) topical or oral		
Bacitracin Ointment (Neosporin)		
Tums or generic equivalent		

I give permission for the School Nurse or Designated Personnel to dispense the above selected OTC medicine(s) to my child. Your signature gives permission to each over-the-counter medication selected to be administered to your student.

**Parent or Guardian Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please list any medication or food **allergies:** \_\_\_\_\_

Any other **medical information** you would like to share: \_\_\_\_\_

### **EMERGENCY CONTACT NUMBERS:**

**Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_