Chartiers-Houston School District

Medical Information 26-27

Student's Name: _____ Grades: 8,9,10,12

1. Has your child had a serious illness, accident, or operation? Yes No
   If yes, please list:
   _____

2. List any diagnosed health conditions, include old and recent conditions:
   _____

   _____

3. Is your child allergic to bee stings, medicine, plants, or food? Yes No
   If yes, describe allergen, reaction and what relieves symptoms:
   _____

4. Does your child take medication on a daily basis at home? Yes No
   If yes, please list: _____
   _____

5. Will your child need medication regularly at school? Yes No
   If yes, please contact the school nurse on the first day of school.

6. List any other concerns: _____

My child may be given Tylenol/Advil/Cough Drops/Antacids at the discretion of the School Nurse and in accordance with orders of the School Physician.

_____ _____
Date Parent/Guardian Signature

Information provided by my physician or me is used to update the student medical record. To ensure the safety of my child, information may be shared with school staff and emergency care personnel.

_____ _____
Date Parent/Guardian Signature