2016-2017 Medical Information
Murray County Central

Dear Parents/Guardians:
Please complete the following health information for your child and keep us informed if there are any changes in your child's health or medication needs.

Student Name_____ Grade_____

Parent/Guardian
Name(s)_____

Medical History: Check all that apply and explain conditions marked in the chart below:

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drug, latex)			Concussion		
Allergies (seasonal)			Hearing Impairment		
Asthma or breathing problems			PE Tubes		
ADHD/ADD			Heart problems		
Anxiety			Migraines		
Depression			Scoliosis		
Bladder Concerns			Seizures		
Bleeding Concerns			Skin Conditions		
Bowel Concerns			Stomach Disorder		
Dental problems			Surgery		
Diabetes			Visual Impairment		
Low Blood Sugar			Glasses/Contacts		

Describe any other important health-related information about your child (for example: hospitalizations, fractures, other health concerns, etc.):

_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

If a prescription medication or an inhaler needs to be administered at school, please contact the school nurse for the medication administration form.

The medications listed below will be administered only when absolutely necessary. If you know that your child may need the below over the counter medications during school, you may provide them for your child and they will be kept in the nurse's office. According to school policy, no medication will be given without yearly written parental permission.

My child may have the following medications as needed, which will be administered by the school nurse or staff member:

Ibuprofen (Motrin) _____Yes _____No
Acetaminophen (Tylenol) _____Yes _____No

Parent/Guardian Signature_____Date_____