STUDENT INFORMATION SHEET CONTINUED:

Student's Name ____________________

Homeroom or 1st Period Teacher ____________________ Grade ________

Special Problems: List anything you feel your child's teacher should know to better understand him/her:

____

____

____

Health Problems: ____________________

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At times, over-the-counter medications can be given at school by the school nurse for simple health problems. Please write your initials next to which medications you may allow your child to receive during the school day if needed.

_____ Throat Spray | _____Tums | _____Advil or generic

_____ Tylenol or generic | _____ Anbesol | _____ Contact Solution

_____ Antibiotic Ointment | _____ Hyrocortisone Cream | _____ Benadryl or generic

_____ Eye Drops | _____ Burn Ointment | _____ Insect Sting Relief Spray

_____ Sunscreen

Current Medications: ____________________

____

____

Allergy (Medications, Foods, Stings etc.)	**Type and Severity of Reaction** (Hives, Runny Nose, etc.)	**Treatment/Medication**

Please list any serious illnesses, head injuries, fainting episodes, fractures, or immunizations that occurred over the summer month (immunization dates must be on Primary Care Provider's letterhead):

____

____

I AUTHORIZE MEDICAL PERSONNEL TO RENDER NECESSARY TREATMENT TO MY CHILD IF NEEDED. I UNDERSTAND THAT MY CHILD MAY BE SENT TO MY FAMILY DOCTOR OR EMERGENCY ROOM AT PARENT/GUARDIAN'S EXPENSE.

Family Doctor ____________________ **Family Dentist** ____________________

I CONSENT TO THE RELEASE OF THE ABOVE INFORMATION TO CPSD PERSONNEL TO PROMOTE THE HEALTH AND SAFETY OF MY CHILD. (Please make an apointment with the School Nurse for confidential information.)

I CONFIRM THAT THE INFORMATION PROVIDED ON THIS STUDENT INFORMATION SHEET IS COMPLETE AND CORRECT.

Parent/Guardian Signature ____________________ **Date** ________