
HEALTH INFORMATION

Student's Name: _____

Grade: _____

Permission for Non-Aspirin (Acetaminophen) or Ibuprofen;

- Acetaminophen (Non-Aspirin) or Ibuprofen, at a dose appropriate for my child's weight and age, may be given up to 2 times per School day if my child complains of mild headache or other minor discomfort. It is not necessary to call a parent before providing it.
- If my child complains of mild headache or other minor discomfort, I wish to be notified and I will make a decision about Acetaminophen or Ibuprofen provision at that time.

Acetaminophen or Ibuprofen will be given by the school nurse or a staff member trained in medication provision. Be assured that if your child is complaining of pain on an ongoing basis, if fever is > 100 degrees, or if the child is suspected of being ill, the parent will be notified. In addition, if your child is requesting one of these medications often, the parent will be asked to supply the medication.

Parent's signature

Date

Parent home phone: _____ Parent daytime phone: _____

Please check if student has the following:

- Asthma
- Diabetes
- Seizure disorder
- SEVERE allergies
- Other, please explain: _____

Reminder:

If your child is entering Kindergarten or is an out-of-state transfer, a physical exam and vision exam is required.

If your child is entering 7"grade, a physical exam is required.

**STUDENT HEALTH QUESTIONNAIRE
KEYA PAHA COUNTY SCHOOLS**

Student Name: _____ Parents' Names: _____

Student's Birth Date: _____ Address: _____

Student's Grade: _____ Phone: _____ (home) _____ (Work)

Does your child suffer any of the following chronic illnesses? If so please explain in the space provided:

Diabetes Yes No If yes, indicate the type/amount of insulin taken

Asthma Yes No If yes, what triggers symptoms?

Epilepsy/Seizures Yes No If yes, are there any indicative symptoms?

Migraine Headaches Yes No If yes, are there any signs of oncoming pain?

Other Chronic Conditions Yes No If yes, please explain.

Does your child suffer from allergies of any kind? If so, please indicate what your child is allergic to and explain type of reaction/symptoms:

Insect Stings Yes No Hay fever/seasonal Yes No Peanuts Yes No

Latex Yes No Strawberries Yes No Other Yes No

Does your child carry injectable epinephrine for any allergies? Yes No

Does your child carry an inhaler for any allergies? Yes No

Please list any other medications taken by your child:

Do any of these medications need to be taken at school? Yes No

Please note that a medication form must be filled out and returned to school for each medication taken at school, whether it is carried by the student or given by school staff.

Do you have any other specific health concerns about your child? Yes No

Have there been any major changes in the family situation in the last year such as moving, divorce, loss of someone close, or serious illness? Yes No

Name of child's physician: _____ Office phone number: _____

Name of child's dentist: _____ Office phone number: _____

I understand that the above health information is considered confidential. I authorize the school nurse and superintendent to release above information to staff members involved with my student.

Parent/Guardian Signature: _____ Date: _____