

Medical Form To Be Completed by the Parent/Guardian

Student's Last Name _____ First Name _____ Age Level _____

Birthdate: _____ Male: Female:

Medical History (check all that apply)

Glasses Seizures Ear Tubes Sensitive Skin
 Asthma Heart Condition Eczema Food Sensitivities

Medication Allergies: _____

Diagnosed Food Allergies: _____

Seasonal Allergies: _____

Epi Pen If you checked "Yes" to either Epi Pen or Inhaler, print the additional Food Allergy Action plan OR Asthma Action Plan form to be filled out by your child's doctor and returned to Chapelwood School before the first day of school.
 Inhaler

Health/Medical Concerns or Recent Hospitalization: _____

Prescription and Over-The-Counter Medicines taken at *Home* : _____

Daily School Medicines: _____

Generic Over The Counter Medications (check all that apply)

Parents to supply medicine for student use at Chapelwood School. Medicine to be administered per product label only.

Tylenol Ibuprofen Orajel Neosporin
 Hydrocortisone 1% Cream Benadryl Cream Diaper Rash Cream

Child's Doctor: _____ Phone: _____

Insurance: _____ Policy #: _____

HEALTH INFORMATION RELEASE

I have read and agree the information on this form, with any initialed changes, is correct. I give permission for the information on this health form to be shared with school personnel on a need to know basis in order to provide appropriate services for my child. I give permission for the nurse at Chapelwood School to contact my child's doctor in order to discuss any medical issues or information regarding my child. I agree to notify the school of any changes in my child's health status.

EMERGENCY TREATMENT RELEASE

In the event of an emergency, I give permission for treatment of my child by school personnel, nurse and/or physician. The school will notify parents as soon as possible.

 PARENT'S SIGNATURE: _____ Date: _____