Student Name: Date of Birth:

- ◯ Yes ◯ No Asthma → If yes, is inhaler prescribed?_____
- ◯ Yes ◯ No Chicken Pox → If yes, year diagnosed:_____
- ◯ Yes ◯ No Diabetes → If yes, Type I or Type II?_____
- ◯ Yes ◯ No Emotional Problems
- ◯ Yes ◯ No Frequent Headaches
- ◯ Yes ◯ No TB/TB Contact
- ◯ Yes ◯ No Hepatitis
- ◯ Yes ◯ No Hyperactivity
- ◯ Yes ◯ No Infectious Disease → Diagnosis:_____
- ◯ Yes ◯ No Pneumonia
- ◯ Yes ◯ No Rheumatic Fever
- ◯ Yes ◯ No Bleeding Disorder
- ◯ Yes ◯ No Scoliosis
- ◯ Yes ◯ No Seizures → Type:_____
- ◯ Yes ◯ No Skin Disease
- ◯ Yes ◯ No Bone Fractures-1
- ◯ Yes ◯ No Bone Fractures-2
- ◯ Yes ◯ No Physical Handicap-1
- ◯ Yes ◯ No Physical Handicap-2
- ◯ Yes ◯ No Surgery-1 → Date and Type:_____
- ◯ Yes ◯ No Surgery-2 → Date and Type:_____
- ◯ Yes ◯ No Heart Condition
- ◯ Yes ◯ No Orthopedic Device

Current Medications

◯ Yes ◯ No Is student currently taking medications? If yes, please list:

Medication Name	How Much	How Often

Permission for Medications

I give permission for the school nurse to give my child the following medications (according to drug information-the meds are aspirin free):

- ◯ Yes ◯ No ***Acetaminophen*** (Tylenol) for pain, headaches or fever
- ◯ Yes ◯ No ***Tums*** for upset stomach, acid stomach or nausea
- ◯ Yes ◯ No ***Ibuprofen*** for headaches, pain, swelling or fever
- ◯ Yes ◯ No ***Benadryl*** for allergies, sinus congestion, rash or stings
- ◯ Yes ◯ No ***Sudafed*** (Pseudoephedrine) for sinus congestion - 12 years of age and older

Child's Physician		Phone	
Child's Dentist		Phone	

List other medical information :

- ◯ Yes ◯ No Does your child have severe reaction to wasp/ bee/insect stings? Specify: _____
- ◯ Yes ◯ No Does your child have food allergies? List and describe reaction:_____
- ◯ Yes ◯ No Does your child have an Epi Pen?
- ◯ Yes ◯ No Does your child have a special diet/food requirements? List: _____
- ◯ Yes ◯ No Does your child have allergies to pollens or other environmental irritants? List:_____
- ◯ Yes ◯ No Does your child have medication for allergies? If yes, please list:_____
- ◯ Yes ◯ No Does your child have hearing problems?
- ◯ Yes ◯ No Tubes in ears? If yes, list date: _____
- ◯ Yes ◯ No Hearing Aid? Name of ear doctor:_____
- ◯ Yes ◯ No Does your child have vision problems?
- ◯ Yes ◯ No Has your child been seen by an eye doctor?
- ◯ Yes ◯ No Does your child have prescribed corrective lens? Name of eye doctor:

Indicate whether your child has had any of the following difficulties which may require special education services.

- ◯ Yes ◯ No Learning difficulties Date Evaluated: _____
- ◯ Yes ◯ No Physical difficulties Date Evaluated: _____
- ◯ Yes ◯ No Emotional difficulties Date Evaluated: _____
- ◯ Yes ◯ No 504 Plan

Parent Authorization *(please check each)*

- ◯ I authorize emergency treatment.
- ◯ I will provide transportation for my sick child, unless my child is seriously ill or injured.
- ◯ I authorize Grove Public Schools to administer emergency medical care/first aid to my child.
- ◯ I authorize Grove Public Schools to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in their judgement, for the health of my child.
- ◯ In the events physicians, other persons named on this form, or parents cannot be contacted, the school officials are authorized to take whatever actions are deemed necessary in their judgement, for the health of my child.
- ◯ I will not hold the school district financially responsible for the emergency care and/or transportation of my child.
- ◯ Grove Public Schools has notified me of available special education services and programs
- ◯ I authorize the Oklahoma Immunization Service to release my child's immunization records and information located within the Oklahoma State Immunization Information Services (OSIIS) to Grove Public Schools. These records may be included with transcript requests and graduation packets.

Parent Signature: **Date:**