Medical Information Form

Student Name: ____

Any reaction to Penicillin? Yes No	Any dietary restriction? Yes No
Any chronic physical problems? Yes No	Any regular use of medication? Yes No
Any readtion to any other drugs? Yes No	Any known allergies (food/medicine) Yes No
Any use of insulin? Yes No	

Special Medical Problems: (check all that apply)

Diabetes Asthma Heart Conditions Hypoglycemia Arthritis Mono High Blood Pressure

Rheumatic Fever TB Breathing Disorders Migraine Headaches Carpal Tunnel Syndrome

Back Problems Bleeding Disorder Wear glasses/Contacts Knee/Ankle Injuries

Any Fractures/Surgeries (location)______________________________ Other (Please describe below)

If you answered YES to any of the above items, please explain:

Non-Prescription Medication: Check those Over-the-Counter Medications you **do not** give permission for staff to administer:

Aspirin Tylenol Advil Ibuprofen Antacids Cough Cold & Sinus Cold & Flu Anti-diarrheal

Allergic Reaction Laxative Topical Ointments, Creams, Lotions.

If you have a preference or special need for a specific Over-the-Counter medication, it is your responsibility to supply the chaperone with that medication.

Prescription Medication: My child/ward has my permission to take the following MEDICATION as prescribed by our family doctor. *We understand that should our child/ward be found in possession of any prescription drug not specified herein, disciplinary action may be taken.* Please attach Doctor's Note if necessary.

Name of Medication	Condition for Medication	Time/Frequency	Dosage
1.			
2.			
3.			
4.			

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(Signature of participant) (Date) (Signature of parent/guardian) (Date)

I, ____________________________ agree to administer the prescriptions as stated above to the student.
(Chaperone)

Jefferson County Public Schools