Student Medical History

Derby PUBLIC SCHOOLS

Student's Name: _____ School: _____

Complete the following checklist by indicating any of the following student conditions.

☐ This child has no health needs.

Allergies

☐	Environment	Please list:
☐	Food	Please list:
☐	Insect/Bees	Please list:
☐	Medications	Please list:
☐	Other	Please list:

Health Conditions

☐ ADD/ADHD	☐ Bone/Joint/Muscular Disorder	☐ Migraines/Headaches
☐ Anemia	☐ Cardiac	☐ Obsessive Compulsive Disorder
☐ Anxiety	☐ Convulsion/Epilepsy	☐ Oppositional Defiant Disorder
☐ Arthritis	☐ Depression	☐ Reflux (gastroesophageal)
☐ Asthma Mild ☐ Asthma Moderate ☐ Asthma Severe	☐ Diabetes	☐ Seizures
☐ Autism/Aspergers	☐ Digestive/Bowel Problems	☐ Skin Disorders
☐ Bi-Polar	☐ Down Syndrome	☐ Thyroid Disease
☐ Bladder/Kidney Disorder	☐ Eating Disorder	☐ Tourettes (Tics)
☐ Bleeding/Clotting Disorder	☐ Hypoglycemia	☐ Traumatic Brain Injury

Current Medications *Please provide information in boxes*

Med #1:	Dosage:	Condition:
Med #2:	Dosage:	Condition:
Med #3:	Dosage:	Condition:

Vision **Hearing**

☐	Glasses/Contacts	☐	Hearing Aids
☐	Vision Concerns	☐	Hearing Problems

Healthcare provider information on file *Please provide information in boxes*

Physician	
Hospital	

☐	I acknowledge that the above information relating to the health of my child is current	Signature: Date:

Indicate the medication(s) that your child may receive:

- ❑ Acetaminophen
- ❑ Ibuprofen
- ❑ Benadryl

I give permission for my child to receive ACETAMINOPHEN, IBUPROFEN, and/or BENADRYL (as indicated) when deemed necessary and delegated by the Registered/School Nurse. Dosage will be calculated based on my child's current weight. I understand that a generic equivalent may be used. I understand that the above medications I have checked will be administered by the Registered/School Nurse.

_____ _____

(Date) *(Parent/Guardian Signature)*

Consent for Treatment of Minor Dependents

Student's Full Name: _____Grade: _____

Parent/Guardian Name:_____

Address: _____ Phone: _____

Business Phone: _____ Emergency Phone: _____

If unable to reach responsible party for dependent child,

_____

(Name of Student)

You have my consent to call _____ at _____

(Physician's Name) *(Phone #)*

and/or send to _____ by ambulance if situation warrants.

(Hospital name)

I further give my consent to above physician and/or hospital to care for dependent child at their discretion in the best interest of the child.

_____ _____

(Date) *(Parent/Guardian Signature)*