RAYMOND SCHOOL DISTRICT
CONFIDENTIAL STUDENT INFORMATION FOR NURSE'S OFFICE

NAME: _____ GRADE: _____ DOB: _____

PARENT/GUARDIAN: _____

ADDRESS: _____

Your child primarily lives with (circle one): Both Parents / Mom / Dad / Other _____

Primary Doctor: _____ Phone: _____ Hospital for emergencies: *** _____

Last physical date: _____ (Copy needed in nurse's office for sports and file)

*** In the event of an emergency, the school will make every effort to contact me. If the school is unable to reach me, I give permission for the transport of my child to the hospital via ambulance.

Parent Signature: _____ Date: _____

Has your child had a Tdap Booster recently? Yes ☐ No ☐
If yes, please forward the date of vaccine or disease to the nurse's office.

Does your child have any allergies to medication? (Circle one) Yes No

(If "yes", please list and document reactions)

1. _____
2. _____

Any other allergies: (Bee stings, peanuts/nuts, dairy, seasonal, food, environmental, etc.)

_____ Reactions: _____

Current treatment used at home: _____

Special diet or classroom considerations: (No sugar, no soda, etc.)

_____

_____

Pertinent medical information: (Check any that apply)

__ Heart disease/Murmur
__ Frequent ear infections
__ Seizures
__ Frequent headaches
__ Diabetes
__ Kidney/Bladder concerns
__ Nose bleeds
__ Migraines
__ Asthma (Inhaler? Yes / No)
Currently using: Yes / No
__ ADD/ADHD (Circle one)
__ Contacts/Glasses (Circle one)
__ Menstrual problems
__ Insect bite reactions
__ Frequent sore throat
__ Intestinal problems
__ Dizziness/fainting
__ Recent Mono
__ Other

Please explain any special health concerns for items that were checked above:

_____

_____

_____

IN SCHOOL MEDICATION:

If necessary, I give permission for the school nurse to give my child the following medications:

__ **Benadryl for allergic reactions** (weight appropriate dosage)
__ **Tylenol 325mg tab (1 or 2 tabs)**
__ **Ibuprofen (Advil) 200mg tab (1 or 2 tabs)**
If your child needs chewable tabs, please bring in a supply for your child.
Chewable tabs are not stocked in the nurse's office.
__ **Tums**
__ **Cough drops/throat lozenges**

*** I understand that if my child needs these medications frequently, I will need to bring in a supply for my child. Any and all medications will be kept in the nurse's office.

Parent/Guardian Signature: _____ **Date:** _____

Please list **any medications that your child takes during the day at home** and include dosages:
(This alerts us to possible side effects to watch out for)

_____ Dose _____
_____ Dose _____
_____ Dose _____

EMERGENCY INFORMATION

Father's name _____
Home phone _____
Cell phone _____
Work phone _____
Work address _____
_____

Mother's name _____
Home phone _____
Cell phone _____
Work phone _____
Doctor's name _____
_____

Please list 2 people who may assume responsibility for your sick/injured child and who can pick your child up from school if we are unable to contact you.

Name _____
Address _____
Phone _____
Relationship _____

Name _____
Address _____
Phone _____
Relationship _____
My child usually:
__ Walks home __ Takes bus __ Is picked up

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Information may need to be exchanged between the nurse's office and the physician's office regarding immunizations, physical dates or for emergency purposes.

I give / do not give (*please circle one*) permission for the nurse's office and the physician's office to exchange the above information.
Work address _____

Telephone _____

Parent Signature _____

Email _____