

DAYVILLE SCHOOL DISTRICT 16J
P.O. Box C Dayville, OR. 97825

STUDENT NAME _____ DATE _____

GRADE _____

HEALTH INFORMATION

Does your child have any health problems of which we should be aware, such as:

- | | | | |
|--------------------------------------|---------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> BEE STINGS | <input type="checkbox"/> FOOD ALLERGY | <input type="checkbox"/> SKIN DISORDER | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EYE PROBLEMS | <input type="checkbox"/> ORTHOPEDIC PROBLEM | <input type="checkbox"/> HEART CONDITION |
| <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> EAR PROBLEM | <input type="checkbox"/> CONVULSIONS (EPILEPSY) | <input type="checkbox"/> URINARY ISSUES |
| <input type="checkbox"/> OTHER _____ | | | |

HAS YOUR CHILD BEEN PRESCRIBED AN INHALER OR EPI-PEN? YES NO _____
(Will they 'carry it with them' -or- 'check in it at the office')

DOES YOUR CHILD TAKE MEDICINE REGULARLY? YES NO _____

OTHER IMPORTANT HEALTH INFORMATION _____

EMERGENCY MEDICATION ADMINISTRATION

The school keeps a small supply of non-prescription medications on hand for emergencies.

Please circle any of the following medications that you would like to give school staff permission to administer to your child if needed (per label instructions)

Children's Acetaminophen (Tylenol) 160 mg chewable tablets	Diphenhydramine HCl (Benadryl) 25 mg. tablets	Acetaminophen (Extra Strength Tylenol) 500 mg. tablets	Ibuprofen 200 mg. tablets
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I give permission for my student to take the above medication(s) at school or school related activities. *I further agree that any school employee who administers these medications in accordance with label instructions shall not be liable for damages resulting from the proper administration of these medications.*

Parent Signature _____ Date _____