# 2023-2024 Coffee County Schools
## Student Health History & Over the Counter Medication Authorization

**Student's Name:** **Date of Birth:**

**Grade:** **Homeroom:** **Age:**

Student health information within the school is limited to the information necessary to serve the student's educational and health interests.

| Health Condition | Yes | Details/Date of Last Event | Health Condition | Yes | Details/Date of Last Event |
|---|---|---|---|---|---|
| **Allergies** | | | **Mental/Emotional** | | |
| Bee/Insect Stings | | Reaction: | *ADD/ADHD | | *If yes, is Medication Prescribed? Yes No |
| Environmental | | Reaction: | Anxiety | | |
| Food (specify) | | Reaction: | Autism | | |
| Latex | | Reaction: | Depression | | |
| Medications | | Reaction: | Intellectual Disab. | | |
| Other (specify) | | Reaction: | Eating Disorder | | |
| **Bleeding Disorder** | | Specify: | Harm to others | | |
| **Bone/Joint/Muscle** | | Specify: | Harm to self | | |
| ***Diabetes** | | *If yes, provide Diabetic Supplies | Other (specify) | | |
| Type I | | Glucose checks at school? | ***Migraines** | | *If yes, is Medication Prescribed? Yes No |
| Type II | | Glucose checks at school? | **Mobility limitation** | | Specify: |
| Insulin Dependent | | Insulin injections at school? | Cerebral Palsy | | |
| **Digestive/Bowel** | | Specify: | **Other Medical** | | Specify: |
| **Hearing problem** | | Specify: | **Seizures (Type)** | | Specify: |
| Hearing Aids | | | *Diastat | | *If yes, provide Prescription & Diastat |
| **Heart Condition** | | Specify: | **Skin Condition** | | Specify: |
| **Lungs/Breathing** | | | **Speech disorder** | | Specify: |
| Asthma | | | **Urinary Tract** | | Specify: |
| *Inhaler | | *If yes, provide Prescription & Inhaler | **Vision problem** | | Specify: |
| Nebulizer | | | Glasses/Contacts | | |

***Has an EpiPen been prescribed for your child? *Yes* *No* If yes, what for?

***A DOCTOR'S NOTE MUST BE PROVIDED FOR ANY MEDICAL CONDITION REQUIRING NURSING SERVICES***

__ My child has *NO* health concerns (Please notify Nurse of any new health concerns during the school year)

Does your child take medication on a daily basis (including homeopathic and nutritional supplements)? *Yes* *No*

If yes, please list all medications taken and what they are for: _____

Have there been any family changes in the past year such as separation, divorce, remarriage, death, serious illness or other that may affect your child? Yes No If yes, please explain: _____

Name of Primacy Care Doctor: _____ Phone Number: _____

Name of Specialist Doctor: _____ Phone Number: _____

Child's Insurance Carrier: _____

| Emergency Contact Name | Relation to student | Phone#(s) |
|---|---|---|
| | | |
| | | |

**Please check if you allow your child to take OTC medicine at school, and if so, check the ones you approve to take at school**

____ I *DO* allow my child to take OTC meds at school ____ I *DO NOT* want my child to take OTC meds at school

____ Acetaminophen/Tylenol ____ Benadryl oral ____ Calamine lotion ____ Hydrocortisone Cream ____ Pepto Bismol

____ Antibiotic Ointment ____ Benadryl cream ____ Ibuprofen/Motrin ____ Orageł ____ cough drops ____ Tums

Parent/Guardian Signature: Phone#: Date:

*IF PRESCRIPTION MEDICATION IS TO BE TAKEN AT SCHOOL, SEE THE SCHOOL NURSE FOR MEDICATION FORM*