STUDENT HEALTH INFORMATION

– CONFIDENTIAL FOR CLINIC USE ONLY –

*Please indicate with an * the most reliable phone number where you may be reached during the school day*

Student Name____ Sex ____M ____F

Date of Birth __________________________ Grade ________________ ID#_________________________________

Address____

Parents/Legal Guardians with whom student lives

Name _______________________________________Relationship to Student ______________ Home Phone_____________________

Place of employment ____Work Phone ____________________Cell __________________

Name ___________________________________Relationship to Student __________________Home Phone_____________________

Place of employment ____Work Phone __________________Cell____________________

Other children in Frisco ISD, names and grades____

Name two emergency contacts with permission to pick up child in case parents cannot be reached:

1. _______________________________Home Phone __________________ Work Phone ___________________ Cell ________________

2. _______________________________Home Phone __________________ Work Phone ___________________ Cell ________________

First Aid is given to students while at school if needed. A list of medications (oral & topical) that are used in the school clinic is available on request from the school nurse. School personnel may give TYLENOL or ADVIL (or generic equivalent) for pain or fever, BENADRYL (or generic equivalent) for allergic reactions, TUMS, COUGH DROPS, and SORE THROAT STRIPS with ***parental consent***. ***These are the ONLY oral over the counter medications the nurse may give and should be provided by parents***. ***All*** ***other medications*** (over the counter or prescription medications) must be accompanied by a doctor's written prescription, be properly labeled, and ***in the original container***. A separate permission form ***must*** be signed by the parent/guardian ***before*** the nurse can administer the medication to your child. All medications should be brought to the nurse by the parent/guardian. ***Please check one line below:***

________**Yes.** My child **DOES** have permission to take the above mentioned medications as indicated by school protocol.

________**No.** My child **DOES NOT** have permission to take the above mentioned medications.

Please indicate ***yes*** or ***no*** of any factors or medical conditions of which school officials should be aware:

______ADD/ADHD ______Diabetes * ______Medications taken regularly* ______Serious illness or accident
______Allergies* ______Disability ______Recent surgeries
______Asthma* ______Hearing/Vision ______Seizure (Disorder or history of)* ______Other

**** Please see school nurse for additional forms to complete***

Please explain fully any ***"yes"*** answers____

____

____

Special adaptations while at school? ____

Signature of Parent/Guardian ____ Date_________________________

Please use the back of this form to add any additional information if needed