Highmore Harrold School District
Student Health Form
Request and Authorization for Over the Counter Medication/Treatment

Student: _____ DOB:_____ Phone:_____ Grade:_____

Parents:_____ Address:_____

List all medications your child is currently taking (medication, time, dosing):

AM At school: _____

Noon: _____

PM At School: _____

As Needed:_____

Severe health concerns and/or allergies that the school needs to be aware of: *no* *yes*
If yes please explain: _____
_____

If your child has a prescribed medication to be given at school, please have a signed doctor's order or a copy of the prescription to bring to school and a signed parent permit. If your child is taking an over the counter medication please have a signed parent permit. Forms can be obtained from the school.

Medical Diagnosis: (Check the ones that apply to your son/daughter)

	ADD/ADHD		**Blood Disorder**		**Headaches**		**Seizure Disorder**
	Allergies		**Bones/Skeletal**		**Hearing Problems**		**Skin Disorder**
	Anemia		**Cancer**		**Heart Disease**		**Stomach aches**
	Anorexia/Bulimia		**Dental Problems**		**Kidney/Bladder**		**Surgery**
	Anxiety		**Depression**		**Menstrual Problems**		**Other:**
	Arthritis/Joints		**Diabetes**		**Obsessive/Compulsive**		
	Asthma		**Genetic Disorder**		**Orthopedic Condition**		

Please explain about any condition or other health concerns you may have: _____
_____
_____

This confidential information may be shared with the facility and staff and contracted service providers on a need to know basis. This can help the staff understand any special needs of your child and allows for the best educational plan possible.

I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. In addition, I understand that I am responsible to deliver the medication to the school and to pick up unused medication.

Parent/Guardian Signature:_____ Date:_____