

**STUDENT HEALTH INFORMATION**

STUDENT NAME: \_\_\_\_\_

GRADE: \_\_\_\_\_ AGE: \_\_\_\_\_

If student is on any routine medications please list:

\_\_\_\_\_

\_\_\_\_\_ Do we need to give it at school? \_\_\_\_\_

**ALLERGIES:**

\_\_\_\_\_

\_\_\_\_\_

**ANY CHRONIC HEALTH PROBLEMS SUCH AS EYESIGHT, HEARING, ASTHMA, DIABETES, ETC:**

\_\_\_\_\_

\_\_\_\_\_

**NAME and PHONE # TO CONTACT IN EMERGENCY, IF PARENT CANNOT BE REACHED:**

\_\_\_\_\_

**I hereby grant permission for Banner County School Personnel to dispense non-prescription medication when deemed necessary for the well-being of above named child. I grant permission for information regarding allergies, asthma, etc., to be given to teachers. I grant permission in the event that an illness or accident might occur when a parent is not available, for the school to secure medical attention. Any exceptions to this permission? \_\_\_\_\_**

\_\_\_\_\_

**PARENT'S or GUARDIAN'S SIGNATURE**

**THANK YOU FOR YOUR HELP!  
Marie Parker, RN School Nurse**