Potlatch School District Medical History Form

Student Name: _____ DOB:_____ Grade: _____

Parent/ Guardian Name & Phone #: _____

Primary Health Provider: _____ Phone: _____

Please place a check next to any health conditions listed below that apply to your child:

- ☐ Allergies to: _____
  Severe in Nature? _____
- ☐ Asthma that requires no medications
- ☐ Asthma that requires daily medications or rescue inhalers
- ☐ Internal Irregularities
- ☐ Cardiac Conditions
- ☐ Diabetes
- ☐ Other – Explain: _____
  _____
- ☐ Kidney/ Bladder Infections
- ☐ Musculoskeletal – Fractures, surgical, arthritis
- ☐ Seizure Disorder
- ☐ Sight Impairment w/ Glasses_____
  w/ Contacts_____
- ☐ Hearing Disorder w/ aid_____

1. Does your child take any medications regularly during the day that may need to be delivered at school?
   If yes, please explain: _____
   _____
2. Does your child take any medications daily at home that would be required in the event of an overnight, emergency stay at school such as a lock down? _____
   _____

PLEASE NOTE: **ANY** medication delivered at school must be provided by the parent/ guardian in the original container along with a signed Medication Authorization Form. For prescription medication the Medication Authorization Form must also be signed by your health care provider. Over the counter medications must be accompanied with a Medication Authorization form signed by parent/ guardian with your instruction for dosage and frequency of use. The school does NOT supply over the counter medications such as Tylenol, Benadryl or Ibuprofen.
Inhalers and epi pens may be self-carried by the student if indicated by your primary care provider. All other medications must be checked into the office.

The information provided on this form is accurate and true as of this date. I will provide the necessary paperwork and medications for any medical treatments at school that my child may need and understand that the school staff cannot and will not administer any medication without prior written consent from both the parent/guardian and also the health care provider if it is prescribed.

Legal Parent/ Guardian Signature: _____ Date: _____