DAYVILLE SCHOOL DISTRICT 16J

P.O. Box C Dayville, OR. 97825

STUDENT NAME_____ DATE_____

GRADE_____

HEALTH INFORMATION

Does your child have any health problems of which we should be aware, such as:

□ BEE STINGS	□ FOOD ALLERGY	□ SKIN DISORDER	□ DIABETES
□ ASTHMA	□ EYE PROBLEMS	□ ORTHOPEDIC PROBLEM	□ HEART CONDITION
□ HAY FEVER	□ EAR PROBLEM	□ CONVULSIONS (EPILEPSY)	□ URINARY ISSUES

□ OTHER_____

HAS YOUR CHILD BEEN PRESCRIBED AN INHALER OR EPI-PEN? □ YES □ NO _____

(Will they 'carry it with them' -or- 'check in it at the office')

DOES YOUR CHILD TAKE MEDICINE REGULARLY? □ YES □ NO _____

OTHER IMPORTANT HEALTH INFORMATION_____

_____

EMERGENCY MEDICATION ADMINISTRATION

The school keeps a small supply of non-prescription medications on hand for emergencies.

Please circle any of the following medications that you would like to give school staff permission to administer to your child if needed (per label instructions)

Children's Acetaminophen (Tylenol) 160 mg chewable tablets	**Diphenhydramine HCI** (Benadryl) 25 mg. tablets	**Acetaminophen** (Extra Strength Tylenol) 500 mg. tablets	**Ibuprofen** 200 mg. tablets

I give permission for my student to take the above medication(s) at school or school related activities. *I further agree that any school employee who administers these medications in accordance with label instructions shall not be liable for damages resulting from the proper administration of these medications.*

Parent Signature _____ Date _____