CATOOSA COUNTY PUBLIC SCHOOLS
CLINIC RECORD

PLEASE PRINT
Student's Name_____ Birth Date_____
Parent/Guardian_____ Cell #_____ Work#_____
Parent/Guardian_____ Cell#_____ Work#_____
Student lives with: Mother____Father____S/Mother____S/Father____Grandmother____Grandfather____ Other_____

EMERGENCY CONTACT/PHONE #:_____

MEDICAL INFORMATION/HEALTH HISTORY

Operation (within last year) _____ Emotional Problems (i.e. panic attack, etc)_____
Serious Medical Problems or Past Health Problems_____
Diabetes___Epilespy___Allergies___Asthma___Tetanus___(date)_____Drug Allergies_____
Is student under a physician's care at this time or has any chronic conditions. YES____NO____ (If yes, list reason)_____
List all medications student is currently taking: _____
Medications to be taken at school_____ Dosage_____ per day. Times to be taken _____ (Medications(s) must be in the original pharmacy bottle with instructions from the physician or in the over-the-counter packaging).
Student must carry an inhaler_____ (brand). Prescription and/or physician's orders are attached.
Student must carry an EpiPen Jr® or EpiPen®_____. Prescription and/or physician's orders are attached.

PLEASE CIRCLE MEDICATIONS THAT MAY BE GIVEN TO YOUR CHILD BY THE SCHOOL NURSE / SCHOOL PERSONNEL

Acetaminophen (Tylenol) 160 mg (Chewable dose per age/weight)	YES	NO	Antacid (Tums)	YES	NO
Acetaminophen (Tylenol) 80 mg (suspension dose per age/weight)	YES	NO	Anti-Fungal Cream	YES	NO
Acetaminophen (Tylenol) 325mg *(circle dose)* 1tab or 2 tabs	YES	NO	Anti-Itch Cream/Spray	YES	NO
Acetaminophen (Tylenol) 500 mg *(circle dose)* 1 tab or 2 tabs	YES	NO	Aloe Vera	YES	NO
Ibuprofen (Motrin/Advil) 100 mg (suspension dose per age/weight)	YES	NO	Burn Spray/Cream	YES	NO
Ibuprofen (Motrin/Advil) 200 mg *(circle dose)* 1tab or 2 tabs	YES	NO	Cough Drops/Throat lozenges	YES	NO
Diphenhydramine HCL (Benadryl) 12.5 mg	YES	NO	OraJel	YES	NO
Diphenhydramine HCL (Benadryl) 25 mg	YES	NO	Eye Drops	YES	NO
Menstrual Relief (Pamprin, Midol) *(circle dose)* 1tab or 2 tabs	YES	NO	Lip Balm	YES	NO

The undersigned hereby releases and agrees to hold harmless and indemnify the Catoosa County Board of Education and any employee of the Board from any liability whatsoever occasioned by the administration or non-administration of the above described medication to your child during school hours in accordance with the above instructions. I do hereby grant the school nurse permission to give treatment, perform hearing and vision screening and/or nonprescription medication to my child based under school health guidelines. I also authorize the school nurse permission to acquire information about my child from his/her health care provider. The undersigned also authorizes the school to seek emergency medical treatment for child when necessary and appropriate.

Parent/Guardian Signature_____ Date_____

School Nurse Signature_____ Date_____