HEALTH PLAN INFORMATION

Student Name:______________________________ **Date:** __________ **Grade**________

Allergies____________________
Bee Sting Allergy_______________
Asthma______________________
Diabetes_____________________
Seizures_____________________
Heart Condition ______________
Kidney/bladder________________
Arthritis_____________________
Vision impairment_____________
Glasses/contacts______________

Ear/Hearing________________________
Motion Sickness_____________________
Physical handicap___________________
Congenital defects___________________
Skin condition ______________________
Menstrual problems__________________
Daily medication:____________________
reason, dosage_____________________
Other important medical history:________
____

ONLY the following medical information is to be shared with teachers and school staff:
____
____

In case of serious illness or injury, I give my permission for the above named student to be treated at Porter Hospital Emergency room.

Parent Signature____ **Date** ____________

Wheeler Health Services
Student Acetaminophen Permit
(High School Students Only)

My child named above has my permission to take acetaminophen (Tylenol-like) at school
The dose I am authorizing to be given to my child as needed for pain is:

_____ 2 tablets acetaminophen (Tylenol-like) 325 mg.

_____ 1 tablet acetaminophen (Tylenol-like) 325 mg.

Parent Signature______________________________ **Date**_____________________

This permission is for Acetaminophen, a **one time use only.** Any other medicines, whether prescription or non prescription must be supplied by the student's family and a medication form must be filled out and signed by the parent.