

Medical History

This information is confidential and will only be shared with District Six employees who have a legitimate need to know, per HIPAA guidelines.

MEDICAL HISTORY:

Is there any information about your child's physical or mental health that we need to know including:

(Please check all that apply)

- Bronchitis Asthma Stomach upsets Fatigue
 Diabetes Seizures Allergies Sickle Cell
 Emotional Problems

Other: _____

Please describe any illnesses marked above: _____

List any hospitalizations and/or surgeries with dates: _____

Please list all allergies (medications, food, insects, etc)

Allergen	Reaction	Treatment
_____	_____	_____
_____	_____	_____

List all medications your child is currently taking:

Name of Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____

Will your child need these medications while on overnight trips? Yes No

Are there emergency medications your child will need access to while on this trip? (ex: EpiPen, Glucagon, Inhaler) _____

*** PLEASE NOTE:** All medications, not listed below, that need to be administered to your child during this trip will need to be brought by a parent to the School Nurse in the original pharmacy labeled container no later than 2 days prior to the trip. All medications will be kept by and administered by a School Nurse or a District Six Representative.

The following medications will be available for your child if needed. Please check with your child's physician to question any interactions these medications may have with medicine your child may currently be taking.

PLACE A CHECK by the medicines you give permission for your child to take. (Please note: if these medications need to be administered to your child for a time period that exceeds 24 hours, you will be notified.)

- Advil Tums Benadryl Chloroseptic
 Tylenol Immodium Eye Drops Cough Drops
 Caladryl Clear Antibiotic Ointment Insect Sting gel Orajel

I authorize the Nurse or District Six Representative on this trip to administer the above listed medications while on this trip. In case of a medical emergency, I hereby give permission to the Nurse or District Six Representative to secure proper treatment for my child. I further give permission to the physician/hospital to hospitalize, order injections, anesthesia or surgery for my child as deemed necessary. I understand that I will be responsible for any medical bills or hospital expenses incurred. I certify that all the above information is accurate and complete. This authorization is to be effective for this school year only.

Custodial Parent/Guardian Signature: _____ Date _____