

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)

<b>Children's Acetaminophen</b> (Tylenol) 160 mg chewable tablets	<b>Diphenhydramine HCl</b> (Benadryl) 25 mg. tablets	<b>Acetaminophen</b> (Extra Strength Tylenol) 500 mg. tablets	<b>Ibuprofen</b> 200 mg. tablets
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**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 \_\_\_\_\_