

**Independent School District of Boise City
Elementary Health Form Update
With Medication Authorization**

Child's Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____

It is very important to keep the School Health office aware of any medical problems that occur or change during the school year. In an effort to update your student's files and keep health histories current, please fill out the following information for *each* child who is attending this school.

Does your child have any allergies? Yes No

If yes, please explain: _____

Does your child have any specific medical problems or physically limiting disorders we should know about? Yes No

If yes, please explain: _____

Is he/she on any medication? Yes No

If yes, please list any current medication: _____

Will it be necessary for your child to take medication at school? Yes No

Do you have any concerns about learning problems, speech and/or language problems, short attention span or hyper-activity? Yes No

Has your child seen a dentist in the last year? Yes No

Has your child had their eyes checked in the last year? Yes No

Does your child wear glasses _____ or contact lenses? _____ Yes No

(Parent Signature)

I WILL ALLOW the school nurse and/or authorized personnel to give my child Ibuprofen, Acetaminophen, cough drops or antacids at school for minor problems. (Complaints of headache, pain due to musculoskeletal injury, orthodontic procedures, and/or menstrual cramps, dry throat, and upset stomach and/or indigestion.)

(Parent Signature)

(Date)

*Parents may be asked to consult a physician if their child makes frequent requests for medications (such as three times a week for a two-week period of time.)

This information may be shared with school personnel on a need to know basis.