LAKE HAVASU UNIFIED SCHOOL DISTRICT #1
HIGH SCHOOL HEALTH OFFICE
2013-2014-School year

Last Name_____First_____Grade_____

Address_____Date of Birth_____

PARENT/GUARDIAN INFORMATION: **Please complete *entire* form**
Signature required at end

Name_____Relationship_____
Phone: Home _____Work_____Cell_____
Name_____Relationship_____
Phone: Home_____ Work_____Cell_____
**Emergency Contact Name_____Phone #'s_____
****to be used in case of emergency and will assume temporary care only if you cannot be reached***

I give permission for the nurse or person designated by the administration to give my student the following non-prescription medications: (mark box if to be given):

- ☐ Antacid (indigestion)
- ☐ *Acetaminophen /Tylenol-per weight/age as directed on bottle
- ☐ *Ibuprofen/Advil –one tab (200 mg)-per weight/age directed on bottle
  *For minor pain such as headache, menstrual cramps, muscle soreness, dental pain.

✓ **CHECK ALL CONDITIONS THAT APPLY**

_ **NO KNOWN HEALTH PROBLEMS**

_ Allergy_____
  _ Epi Pen Yes ( ) No ( )
_ If food allergy, notify Aramark (928) 854-5043
_ Anemia
_ Arthritis
_ Asthma- mild - moderate - severe ***(circle one)***
  _ carries inhaler
_ Autism
_ Birth Defect (Chromosomal)
_ Blood Disorder
_ Cancer/Leukemia
_ Cerebral Palsy
_ Cystic Fibrosis
_ Diabetes
_ Eating Disorder
_ Gastrointestinal
_ Hearing
_ Heart Disease/Defect
_ Kidney/Urinary
_ Migraines/Headaches
_ Muscular/Skeletal
_ Physical Activity Restrictions
_ Seizure Disorder
_ Other explain:_____
_____

MEDICATION: Taken at home (Please list medication/s and reason given)

_____

_____

Parent/Guardian Signature_____Date_____