LAKE HAVASU UNIFIED SCHOOL DISTRICT #1
THUNDERBOLT HEALTH OFFICE

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_____
**Other 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: (check appropriate box for YES ☐ or NO ◯)

YES NO
☐ ◯ 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**

- _ 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
- _ **NO KNOWN HEALTH PROBLEMS**
- _ Other explain:_____
  _____

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

_____

_____

Parent/Guardian Signature_____ Date _____