SPARTANBURG COUNTY SCHOOL DISTRICT TWO
HEALTH SERVICES
MEDICAL HISTORY AND INFORMATION 20___ -20__

Please answer all questions completely

Student's Full Name: ____
(Last) (First) (Middle) (Suffix)

DOB____________________ Teacher Name /Grade Level ____

Student's Home Address____

	Parent/Guardian Name	Parent/Guardian Name
Relation to Student		
Home Phone		
Work Phone		
Cell Phone		
Email Address		

I GIVE THE SCHOOL DISTRICT PERMISSION TO ADMINISTER FOR MY STUDENT THE FOLLOWING:

(Circle Yes or No)

YES NO ACETAMINOPHEN (store brand Tylenol) for minor pain
YES NO DIPHENHYDRAMINE (store brand Benadryl) for EMERGENCY allergic reactions
YES NO ORAJEL for minor toothache
YES NO NON-NEOMYCIN ANTIBIOTIC OINTMENT for minor cuts or abrasions
YES NO CALAMINE/CALADRYL LOTION for minor skin irritations
YES NO CALCIUM ANTACID (store-brand Tums) for minor stomach discomfort

I give Spartanburg School District 2 permission to share the above medical information with members of the school's faculty and staff who have a legitimate need to know, and to contact my student's doctor for additional information as needed.

Parent/Guardian Signature: ____ Date: ______________________

Please mark all illnesses/conditions that apply to your student

______Diabetes____
______ADD or ADHD – Describe____
______Seizures – Describe____
______Asthma – Does your student need to use an inhaler at school?_______Before PE/exercise?____________
(NOTE: Primatene Mist will NOT be used at school)
______Allergies – (food, insect, medication) Describe____
Does your student need to keep an Epi-pen at school? ____
______Heart Trouble – Describe ____
______Sickle Cell Disease __________________ Trait ____________________
______Vision Problems – Describe ____
______Hearing Problems – Describe ____
Other illnesses/conditions ____
Please list all medications your student takes:
____
Will these medications need to be given at school? Yes _____________ No _______________

No medication will be given to any student without written or verbal consent of a parent/guardian.
All medication from home must be in its original container.
All medication administration will be assisted only by the school nurse or other authorized personnel. Parents will be notified when a student is ill and will be expected to make necessary arrangements for **IMMEDIATE** transportation home. For the protection of your student, as well as other students, do ***not*** send a sick student to school. Please remember the health room staff is not allowed to diagnose an illness. The health room is for **EMERGENCY** use only.

FAMILY PHYSICIAN ____
(Name) (Address) (Phone Number)

Family Dentist__________________________

Preferred Hospital_____________________

Please list three people who could pick your student up from school in case of an emergency:

Emergency Contact Name: _______________________________________**Phone**__________________________

Emergency Contact Name: _______________________________________**Phone**__________________________

Emergency Contact Name: _______________________________________**Phone**__________________________

For your student's health record, please send a note to your student's school for any change in transportation.

STUDENT NAME____TEACHER_____________________

ADDRESS____PHONE________________________

DATE	TIME	