PORTLAND PUBLIC SCHOOLS HEALTH INFORMATION RECORD

Grades 6-12

Student Name _____ DOB _____ Grade _____

Address _____

Parent / Guardian _____

Phone: Cell _____ Work _____ Home _____

Emergency Contact _____ Phone _____

Doctor _____ Phone _____

ALLERGIES ☐ NONE **If YES, please list.**

Does your child carry an Epi-Pen? No Yes	Food No Yes
Bees No Yes	Medications No Yes
Latex No Yes	Other No Yes

DAILY MEDICATIONS ☐ NONE

1)	3)
2)	4)

MEDICAL CONCERNS ☐ NONE

- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Cancer/Blood Disorder
- ☐ Dental Concerns
- ☐ Diabetes
- ☐ Glasses/Vision Problems
- ☐ Hearing Loss
- ☐ Heart Problems
- ☐ Mental Health/Emotional Concerns
- ☐ Seizure Disorder
- ☐ Other Medical Concerns

In the past year, has your child been out of the country for more than 6 months? No Yes If Yes, where? _____

Can this information be shared with staff, if needed? No Yes

I give the Nurse and/or Health Assistant permission to give my child:

Acetaminophen/Tylenol No Yes **Ibuprofen/Advil No Yes** **Antacid Tablets/Tums No Yes**

Parent/Guardian Signature _____ **Date** _____