AMERICAN COMMUNITY SCHOOL HEALTH RECORD

Name of Child _____ Sex _____ Grade _____
(last) (first) (middle)

Date of Birth _____ Place of Birth _____

Name of Parent or Guardian _____

Address _____Home_____
_____Office_____

Mobile (father) _____
Mobile (mother) _____

Name and telephone of relative/friend to call when unable to reach parents:

Name_____ Telephone _____
Name_____ Telephone _____

SCHOOL SCREENING TESTS

(Conducted by School Nurse)

Vision

Date	Results

Hearing

Date	Results

Vision (continued)

Date	Results

Pediculosis

Date	Results

Please state any health problems or allergies that your child may have or medications that your child is currently taking:

_____

_____

PARENTS CONSENT TO ADMINISTER MEDICATION

Non – prescription medication will only be administered by the Health Office to those students whose parents have given written consent.

	YES	NO		YES	NO
Advil /Ibuprofen (pain/fever)	_____	_____	Cough syrup/throat lozenges	_____	_____
Paracetamol (non aspirin pain reliever)	_____	_____	Antacids (for indigestion)	_____	_____
Depon Syrup (children's paracetamol)	_____	_____	Anti – emetics (for nausea)	_____	_____
Anti – allergy	_____	_____	Anti – diarrhea	_____	_____

Parent's signature _____

Name _____ last _____ first _____ middle _____ Sex _____ Grade _____ School Year _____

Visits to the Health Office

Date	Findings