AMERICAN COMMUNITY SCHOOL HEALTH RECORD CARD

Name of Child_____Sex_____Grade _____
(last) (first) (middle)

Date of Birth_____ Place of Birth _____

Name of Parent or Guardian _____

Address _____ Home _____

Office _____

Mobile (mother) _____

Mobile (father) _____

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

Name_____Telephone _____

Name_____Telephone _____

SCHOOL SCREENING TEST

(Conducted by School Nurse)

Vision

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 (pain/fever)	_____	_____	Antacids (for indigestion)	_____	_____
Depon Syrup (children's paracetamol)	_____	_____	Anti – emetics (for nausea)	_____	_____
Anti – allergy	_____	_____	Anti – diarrhea	_____	_____

Do you consent to the sharing of the student's health related information and/or conditions with the appropriate personnel: YES NO

Parent's signature _____

Name_____
last first middle

Sex_____ Grade_____ School Year