Student No.: _____
Name:_____
_____

TRINITY HIGH SCHOOL
STUDENT HEALTH INFORMATION FORM
(revised January 2019)

The following information will help the school nurse and staff better understand your son's medical needs. All requested information is essential to have on record in case of an emergency.

Check if any of the following exist:
Allergies
_____ Bee sting, treatment _____
_____ Latex, treatment _____
_____ Peanuts, treatment _____
_____ Respiratory, treatment _____
_____ Medication, treatment _____
_____ Other _____

Check if any of the following exist: <u>please provide details on the back of this form</u>

_____ Diabetes
_____ Diagnosed learning disability
_____ Hearing issues
_____ Heart condition
_____ Stomach issues
_____ Other
_____ Major Surgeries
_____ Migraine Headaches
_____ Mobility issues
_____ Seizures
_____ Vision issues

Medications:
Please list any daily medications, prescription (including inhalers) or over the counter, your son takes: *(Include dosage and times he takes the medication.)*
_____
_____
_____

Over the Counter (OTC) medications to be administered.
My son may have the following OTC medication(s) – administered according to label directions as needed (CHECK).

_____ Acetaminophen _____ Ibuprofen _____ Cough Drops

_____ Antacids _____ None

- **If medication is prescribed to be administered during school hours contact the school nurse.**
- **All prescription and over the counter medications must be brought in the original container to the Student Affairs Office and signed in by the school nurse.**

PARENT SIGNATURE _____ DATE _____