



Philomath Public Schools

Benton County School District 17J, 1620 Applegate Street, Philomath OR 97370 (541) 929-3169

Philomath School District Student Health Information

Student Name: _____ DOB: _____ Grade: _____

In an effort to effectively track any health concerns, we are asking you to provide **CURRENT** medical information for your student. Please indicate if your child is affected by any of the following: (please circle yes or no).

Will your student need to take medication while at school? YES or NO

*If yes, please fill out the Authorization for Administration by School Personnel form. We cannot administer ANY medication to a student without specific prescribed orders by a provider. ALL medications must be in the original container with a current prescription label attached. Students are not allowed to carry any medication without proper authorization by parent and school administration. You may leave over the counter (OTC) medications for your student in the office in the original container (please check the expiration date. We cannot administer expired medication of any kind). If you would like to keep OTC medication in the school office fill out the Authorization for Medication Administration by School Personnel form.

- **Diabetes** Yes No **If yes, please submit orders/protocol from your provider.**
- **Seizures** Yes No **If yes, please submit orders/protocol from your provider.**
- **Asthma** Yes No **If yes, please fill out a medication administration form**
(If a medication or inhaler is required for your student).
- **Allergies** Yes No Epi-pen * YES or NO Antihistamine * YES or NO
****If yes, please fill out anaphylaxis emergency care plan form and/or medication form**
If yes, please explain _____

- **Bee Sting Allergy** Yes No Epi-pen *YES or NO Antihistamine *YES or NO
****If yes, please fill out anaphylaxis emergency care plan form and/or medication form.**
If yes, please explain _____

- **Other:** _____

Emergency Action: If your student has known SEVERE allergic reactions or other medical issues that require special immediate attention, please provide details of necessary actions:

Emergency medical permission: In case of an emergency and immediate attention needs to be given to my child, I give permission to, and assume full responsibility for, school authorities to send my child to a provider or hospital. I understand the school assumes no financial obligation for expenses incurred in carrying out emergency procedures and/or emergency transportation, and every attempt will be made to reach me (parent/guardian) first.

***Parent/Guardian Signature** _____ **Date** _____