THOMAS FAY CUSTER SCHOOLS
SCHOOL HEALTH HISTORY
CONSENT FOR TREATMENT

Student's Name_____Date of Birth_____
Student's Mailing Address_____
Student's Physical Address_____

Parent/Guardian_____Home Phone_____
Work Phone_____Cell Phone_____
Other emergency contact person and phone_____
(name and number)_____
Student's Medicaid or Sooner Care #_____
Student's Social Security Number_____

Student's Doctor_____

Medical History:
Allegies_____

Any medical conditions that must be observed? (ex: asthma, diabetes)_____
_____

List any medications you give permission for qualified school personnel to monitor or administer at school. Be sure to include name of medication, dose and time of administration:_____
_____

The school keeps tums, sore throat lozenges, and cough drops on hand for students. Please initial if you give permission for school personnel to administer to your child:
_____Yes I give permission _____No do not administer

The school keeps acetaminophen (Tylenol) on hand for students with mild fever, headache or mild pain. Please initial if you give permission for a school personnel to administer to your child:
_____Yes I give permission _____No do not administer

_____I do not wish for my child to receive any medication at school_____

Please list any other information you feel it is important for school health personnel to know about your child and then sign the bottom of the form as verification that you are the parent or guardian.
_____
_____

Parent/Guardian Signature_____Date_____

PLEASE NOTE: That for your child to receive any other me3dication not listed on this page, you must send the medication to school with the child as well as written consent for qualified school personnel to administer, otherwise we will call to get your consent and send a form home that afternoon for your signature before any doses can be given.