Arlington Catholic High School Health Record Information

STUDENT'S NAME _____

Last **First** **Year of Graduation**

Dear Parent / Guardian,

A confidential health record is kept on your child throughout the school years.

As your child is now entering High School, it is important to update their record. It is imperative that the health record include any: **food/drug allergies, disabilities or chronic conditions** whether being treated or not.

Please note any ***Medication Allergies, Current Medications or Conditions*** that we should be aware of..

Medication Allergies:

Medical Conditions:

Medications:

With your permission, we will dispense any of the medication/s you **check off** when deemed necessary. We ask that you **sign below** if you would like your child to receive this service. This will not be done without your approval. **Thank you in advance for your cooperation.**

Tylenol ___
Advil ___
Ibuprofen ____
Neosporin ointment ____
Bacitracin ointment ____
Tums____
Pepto Bismol____
Icy hot____
Mineral ice ____
Caladryl lotion _____
Benadryl Cream _____
Burn spray ____

Name of Parent/Guardian_____(Please Print) **Relationship** _____

I the undersigned parent or guardian, give permission to the school nurse (or school personnel delegated by the school nurse) to administer the above medication to my child. I authorize the school nurse to share information about the medication administration as the school nurse deems necessary for the health and safety of my child.

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