

York County School of Technology
Medical Information Form

Student Name: _____ Gender: M ___ F ___
Last First Middle

Date of Birth: _____

Hospital Preferred: _____

Name/Type of Health Insurance: _____

Name of Parent(s)/Legal Guardian: _____

Phone number of Parent/Legal Guardian: Home _____ Cell _____

Permission for the following medications to be given to my child during school hours and according to first aid orders. *Please check for permission to give specific medication. See first aid orders or school nurse for dose/limits.

___ Acetaminophen (Tylenol) ___ Ibuprofen (Advil) ___ Antibiotic Cream
___ Kaopectate ___ Lozenge/Cough Drop ___ Visine eye drops ___ Antacid/Tums

NARCAN (Naloxone) POLICY: In the event of drug overdose, Narcan (Naloxone) will be utilized per board policy.

***Epipens & Inhalers may be carried by a student provided it is registered with the nurse.**

Health/Medical Issues (Example: Seizures, Asthma, ADD/ADHD): _____

Medications child is prescribed/Daily Medication: _____

Does your child have any severe allergies? Yes ___ No ___ What treatment is needed if child has an allergic reaction?

Permission is granted at no expense to the school or its personnel to take my child to the hospital if warranted. If you have any questions/concerns about your child's medical problems or about the medication policy, please call Mrs. Melhorn, school nurse at 741-0820 Extension 5124.

Signature of Parent/Guardian _____ Date _____