Royall School District 2025-2026 Health Information Form

Last Name	First Name	Date of Birth	Grade

Health Information

Does your child have any of the following? (Please circle Yes or No) _____**NO TO ALL**

Yes No Allergies
_____

Yes No Food Allergy _____
Epi-Pen Yes No

Yes No Bee Sting Allergy
Epi-Pen Yes No

Yes No Asthma
Inhaler at school Yes No
Nebulizer treatments Yes No

Yes No Vision issues? Glasses or Contacts (circle)

Yes No Hearing issues?
Hearing Aid ____R ____L

Yes No Gastrointestinal

Yes No Genetic Disorder/Syndrome

Yes No Neurological/Brain Injury

Yes No Depression

Yes No Anxiety

Yes No Orthopedic

Yes No Scoliosis

Yes No Headaches/Migraines

Yes No ADD/ADHD
Treatment: _____

Yes No Autism

Yes No Seizures

Yes No Diabetes Type 1 or Type 2 (circle)

Yes No Heart Problems

Yes No Other:_____
_____
_____

Yes No Medications

Describe significant medical conditions that affect your child:

If your child has any health concerns that require special instructions, please speak to the nurse to discuss action plans.

Medication	Dose	Time Taken

The above information is correct to the best of my knowledge. Should changes occur, I will notify the school nurse to ensure appropriate understanding of my child's health status. This information will be shared with appropriate school staff to assure a safe environment for my child.

Parent Signature_____

Student Physician	Phone Number
Student Dentist	Phone Number
Student Health insurance:	

Student's Name: ______________________________________

Listed below are non-prescription medications that the nurse has available to give to students. Select the medications you allow to be given on an as needed basis. We hope that using these medications, as needed, will reduce absenteeism and student discomfort. If a student needs routine medications, or begins requesting these medications often, other arrangements must be made. The student then **MUST have a Medication Request/Consent form completed prior to medication being routinely given at school.**

Stock Medication
I authorize Royall School District to administer the following over-the-counter medication based on package dosing guidelines, as needed. *(No chewable or liquid forms (other than antacids) will be available from the school – parents must provide).* **Select all that apply:** _____ **Acetaminophen (Tylenol)** 325 mg, tablet, 1-2 every 4-6 hours for headache/pain. _____ **Ibuprofen (Motrin)** 200 mg, tablet, 1-2 every 4-6 hours for headache/pain. _____ **Calcium Carbonate (Tums)** 500 mg, tablet, 1- 2 tablets for upset stomach/indigestion. _____ **Cough Drops** 1- 2 every 4 hours for cough or sore throat. _____ **Bacitracin - Antibacterial Ointment** for minor wounds or abrasions. _____ **Hydrocortisone - Anti-Itch Cream** for itching or rash.
I certify that my child has no known allergies to the above checked medications. **Medication allergy** please list:____ I herby give permission and authorize the Royall School District Staff to administer the above selected OTC Medication(s) based on package dosing guidelines and release the district and employees from any liability claims as a result of the administration of the above selected medications. I will notify the school nurse/staff of any medications given to my child prior to their arrival at school.

Parent/Guardian Signature	**Date**

Medication Administration Record

(To be filled out by school staff)

Date	Time	Medication	Signature