ARAPAHO-BUTLER PUBLIC SCHOOLS
Health History

Student's name _____ Grade _____
Student's address _____
Street/Apt.# City/State zip code

Parent/Guardian _____ Home phone _____
Work Phone _____ Cell phone _____
Other emergency contact (name & phone #) _____
_____

Student's Social Security # _____ Date of Birth _____
Student's Doctor _____ Date last seen _____
Dentist _____ Date last seen _____
Optometrist _____ Date last seen _____

Medical History:
Allergies _____
Illnesses (include dates) _____
Hospitalizations (reason & dates) _____
Any medical conditions that must be observed?(ex. Diabetes, asthma) _____
_____

List any medications you give permission for school personnel to monitor or administer at school: (include name of medicine, dose & time)
_____
_____
_____

Please list any other health information you feel is important for school personnel to know about your student._____
_____

Please list below any over the counter medications that may be administered to your child during school hours without parental intervention.

_____
(ex. Tylenol, cough medicine, cough drops etc.)

Arapaho Public Schools will not supply any over the counter medications. If you want your child to be given any medications, you must supply it in a **new sealed bottle** with your child's name marked on it.

** I give my permission for school personnel to administer the above medications to my child _____ if needed.
(child's name)

_____ _____
date (parent/guardian signature)

** I do not give my permission for school personnel to administer any medication without my prior consent.

_____ _____
date (parent/guardian signature)