PORTLAND PUBLIC SCHOOLS STUDENT HEALTH INFORMATION
Grades 6-12

Student Name______________________________DOB________________Grade______
Address____
Parent/guardian____
Phone cell__________________________home__________________work___________
Emergency Contact_______________________________________phone____________
Doctor____phone____________

ALLERGIES				DAILY MEDICATIONS ☐ NONE
Food	Y	N	________________	________________________________
Medications	Y	N	________________	________________________________
Bees	Y	N	________________	________________________________
Latex	Y	N	________________	________________________________
Other	Y	N	________________	________________________________
Does your child carry an epi-pen? Y N				

Does your child have: ☐ NO medical concerns

- ☐ Asthma____
- ☐ ADD/ADHD____
- ☐ Cancer/Blood disorder____
- ☐ Cerebral palsy ____
- ☐ Dental Concerns____
- ☐ Diabetes____
- ☐ Glasses/vision problems____
- ☐ Hearing loss____
- ☐ Heart problems____
- ☐ Mental health/emotional concerns____
- ☐ Seizure disorder____
- ☐ Other____

In the past year has your child been outside the US for more than 6 months? Y N
If yes, where?____

Can this information be shared with staff, if needed? Y N

I give the nurse/health assistant permission to give my child:
Acetaminophen (Tylenol) Y N Ibuprofen (Advil) Y N Antacid (Tums) Y N

Parent signature___________________________________Date________________ 5/2017