

Hancock County Technical Center Health Form

Student Name: _____

HCTC Program: _____ All Day Student ___yes ___ no

The Health Office will have Tylenol, Advil, Pepto Bismol, Tums, Benadryl and cough drops available on an as needed basis for your child throughout the school year. These will be **dispensed by the School Nurse or the Administrative Assistant only**. Please sign if you want your child to be able to obtain these medications. Your child **WILL NOT** be able to get these unless we have a signature here:

Guardian Signature

Date

This permission is for the entirety of the student's enrollment at HCTC.

Please help us to provide your child with a healthy school experience by completing this confidential survey. **Information will be shared only on a need to know basis.** Check the following conditions that apply to your child. Include a brief explanation and any dates where appropriate in the space below (you may use the back if necessary). Please notify the school nurse with any concerns/questions.

___ No known health problems

___ Allergy bee sting (circle all that apply)

Rash – mild or severe

Swelling at site of sting

Breathing problems

Epipen/benadryl **(need MD order)**

___ Allergy to food (circle all that apply)

Rash – mild or severe

Breathing problems

Epipen/benadryl **(need MD order)**

___ Allergy to medication (*please list)

___ Asthma (circle all that apply)

Exercise induced

Currently carries inhaler **(list)**

History of asthma, not currently active

___ Attention Deficit Disorder/Attention

Deficit Hyperactive Disorder

___ Autism

___ Cystic Fibrosis

___ Diabetes (Insulin or Diet controlled)

___ Hearing/Vision Problems (please explain)

___ Heart Condition (please explain)

___ Seizures (list medication and explain)

Explanations: _____

Con't _____

Other Pertinent Information (please list):

List all prescribed medications your child takes on a regular basis.