Student: _____

Stafford Public Schools Health Information

2020-2021

List all medications and dosage your student currently takes at home or school:

_____

_____

If your Student needs to take medication at school, the "Authorization for the Administration Form" is linked below. These forms must be completed for any medication a student will need to take during school hours.

Does your student have any known allergies?

Yes	No			Yes	No		
☐	☐	Seasonal	Reaction: _____	☐	☐	Food	Reaction: _____
☐	☐	Insect Sting	Reaction: _____	☐	☐	Other	Reaction: _____
☐	☐	Latex	Reaction: _____	☐	☐	Other	Reaction: _____

Does your student (check all applicable boxes):

Yes	No		Yes	No	
☐	☐	Wear Glasses/Contacts	☐	☐	Hearing Impared
☐	☐	Have Asthma/Respitory Ailments	☐	☐	Have Diabetes
☐	☐	Had a Head Injury	☐	☐	Have Connvulsioins/ Seizures
☐	☐	Have Heart Problems	☐	☐	Have Any Medical Conditions not Listed
☐	☐	Use a Wheelchair or Walker			

Please explain any conditions marked above: _____

_____

Authorization for the Administration of Medication Form

_____

Parent/ Guardian Signature Date

_____

Printed Name