



## Medical Allergies

Is the Student/Patient allergic to or has had a reaction to:	Yes	No		Yes	No
Any medicines (Penicillin or other antibiotic)	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics (including lidocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Any foods (including lactose intolerance)	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any allergies:					

Is the Student/Patient taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, contraceptives, pain relievers, diuretics, laxatives, herbal remedies, or allergy medications?     Yes     No    Please list medications below.

NAME OF MEDICATION	DOSE	FREQUENCY

The School-Based Health Center has my permission to administer the following medications at the discretion of the medical provider. Please check.

	Yes	No		Yes	No
Tylenol/Acetaminophen	<input type="checkbox"/>	<input type="checkbox"/>	Motrin/Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Cough Drops	<input type="checkbox"/>	<input type="checkbox"/>	Tums/Maalox	<input type="checkbox"/>	<input type="checkbox"/>
Cough Syrup	<input type="checkbox"/>	<input type="checkbox"/>	Zofran	<input type="checkbox"/>	<input type="checkbox"/>
Mucinex	<input type="checkbox"/>	<input type="checkbox"/>	Benadryl	<input type="checkbox"/>	<input type="checkbox"/>
Orajel	<input type="checkbox"/>	<input type="checkbox"/>	Zyrtec or Claritin	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocortisone Cream	<input type="checkbox"/>	<input type="checkbox"/>	Albuterol (Breathing treatment)	<input type="checkbox"/>	<input type="checkbox"/>

Any changes in your family history?

Any changes in your child's medical history? Any recent surgeries or hospital admissions?

Any changes in your child's living or guardian situation?

I am aware of the services provided by Valley Health Care's School Based Clinics and my signature provides consent for my child to continue to receive the services provided.

**X** \_\_\_\_\_  
Signature of Parent/Guardian

**X** \_\_\_\_\_  
Date