

Alachua County Public Schools
 Health Services Department
Health Condition, Allergy and Medication/Treatments

Student Name: _____ DOB: _____ School: _____ Grade: _____

In the event of a serious accident or illness, it is important that the school nurse be aware of student's health condition, allergy, and/or medication/treatments. Please complete and return this form to your child's school nurse so that records can be updated as soon as possible for the safety of your child.

List below any health conditions or allergies your child is diagnosed with at the present time.
1.
2.
3.
4.

List below any medication/treatments your child is presently prescribed.					
Medication/Treatment	Dosage	Reason	Needed: At home	Needed: At school	Needed: At both

Parent/Guardian Name (printed): _____

Parent Guardian Signature: _____ Date: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

If you have any questions please contact your school nurse.

PLEASE RETURN THIS TO THE SCHOOL NURSE FOR RECORDS TO BE UPDATED.