US HEALTH FORM

Homeroom_____

Grade_____

Student's Name _____ Birthdate _____

Parents _____ Home Phone _____

Address_____

Father's Employer_____Phone_____Cell Phone_____

Mother's Employer_____Phone_____Cell Phone_____

Grandparent(s)_____Phone_____Email_____

Grandparent(s) Address_____

Family Doctor_____Phone_____

Do you grant permission to school personnel to contact a local doctor in the event your family doctor named above Is not available? Yes No

Do you grant permission to school personnel to take your child to any hospital? Yes No

If your answer to either of the two previous is "no", please give alternate instructions. _____

_____

Name of preferred hospital_____Phone_____

Persons to contact in case of emergency if parents cannot be reached:

_____

Name Relationship Phone

_____

Name Relationship Phone

Does your child have any of the following health problems? (Please circle)

Fainting spells Epilepsy Diabetes Allergies (please list) _____

_____

Please note any information the school should have regarding your child's health.

_____

Please list any medications your child is taking._____

_____

Please read and sign the nonprescription medication authorization on the back.

No medication, prescription or nonprescription, will be administered to a student without a parent's written authorization. Students will not be allowed to call home for permission to take any type medication. Medication Authorization Forms are available in the Counselors' offices.

I give my permission for school personnel to administer the following nonprescription medications to

_____
Student's name

Please check each medication your child may take **and give the allowed number of tablets per dosage.**

_____Tylenol _____500 mg. tablet(s) maximum for one dosage

_____Ibuprofen _____200 mg. tablet(s) maximum for one dosage

_____antacid _____tablets per dosage

_____visine

I hereby release Houston Academy, its directors, officers, employers, and agents from any and all liability, of any nature or character, which may be alleged to arise out of or relating to the administration of the medication described above, provided such administration is in substantial conformity with the above instruction.

Parent's signature_____Date_____

NOTE: If at any time the school determines that your child is requesting excessive medication, you will be notified.

FOR OFFICE USE ONLY:

DATE	MEDICATION & DOSAGE	REASON	ADMINISTERED BY