



Tesseract School
Engaging Minds. Inspiring Dreams.

HEALTH OFFICE INFORMATION FORM

STUDENT NAME _____

GRADE _____

ALLERGIES (FOOD, MEDICATION, ETC.) _____

CURRENT MEDICATIONS _____

HEALTH CONCERNS WE SHOULD BE AWARE OF _____

VISION PROBLEMS _____

HEARING PROBLEMS _____

HOW WILL YOUR CHILD REACT IF THEY ARE INJURED OR ILL? _____

PHYSICIAN _____ PHONE No _____

HOSPITAL PREFERENCE _____

THE FOLLOWING ITEMS ARE AVAILABLE IN THE HEALTH OFFICE FOR USE IN THE EVENT OF ILLNESS OR INJURY. PLEASE CHECK THE BOX FOR EACH ITEM WE MAY USE FOR YOUR CHILD: *Please note: if your child will need allergy medication or antacids during the school day you will need to fill out a medication form and bring in your own supply.*

HYDROGEN PEROXIDE

CALADRYL LOTION

COUGH DROPS

BACITRACIN OINTMENT

VASELINE

IBUPROFEN (ADVIL/MOTRIN)

STERILE EYE WASH

ACETAMINOPHEN (TYLENOL)

CHILD'S WEIGHT _____

DOSAGE: GIVE DOSAGE RECOMMENDED FOR WEIGHT

OTHER _____

I GIVE PERMISSION FOR THE ABOVE CHECKED ITEMS TO BE USED IF NECESSARY

PARENT SIGNATURE _____

DATE _____