



"The Mission of BCSC is to ensure all students develop academically, creatively, physically, and socially into the finest version of themselves."

Health History 2021 - 2022

Student Name: _____ **Nickname:** _____ **Grade:** _____

Medical Diagnoses: _____

Medications taken at home: _____

Medications to be taken at school: _____

Medication Allergies: _____ **Reaction:** _____

Surgeries: _____ **Comments:** _____

Major Injuries: _____ **Comments:** _____

Recurring Illness/Infection: _____

Concussion: _____ Yes _____ No **Date(s):** _____

Do any of the above prevent full participation in physical education? _____ Yes _____ No

Comments: _____

Lactose Intolerant: _____ Yes _____ No **Preferred Substitution:** _____

Last Physical Examination: _____ **Up to Date Immunizations:** _____ Yes _____ No

Last Dental Examination: _____ **Interest in Mobile Dentist:** _____ Yes _____ No

Last Eye Exam: _____ **Glasses:** _____ **Contacts:** _____

Hearing/Ear Problems: _____ Yes _____ No **Wears Hearing Aids:** _____ Yes _____ No

Food/Other Allergy: _____ **Reaction:** _____ **Epi Pen:** _____ Yes _____ No

Asthma: _____ Yes _____ No **Will carry an inhaler at school:** _____ Yes _____ No

Seizures: _____ Yes _____ No **Last known seizure activity:** _____

Nose Bleeds: _____ Yes _____ No **Urinary Issues:** _____ Yes _____ No **Constipation:** _____ Yes _____ No

History of Self Harm: _____ Yes _____ No **History of Eating Disorder:** _____ Yes _____ No

Anxiety/Depression: _____ Yes _____ No **Psychiatric Hospitalizations:** _____ Yes _____ No

Emergency Contact Other Than Guardian: _____ **Number:** _____

Parent/Guardian Signature: _____ **Date:** _____

Please return this form to the Health Center or email to jrichey@benton.k12.in.us



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Over-the-Counter Medications

Student Name: _____

Grade: _____

Students will use the Health Center stock medication supply for the below medications. Over-the-Counter medications do not need to be sent to school.

_____ Acetaminophen 325 mg: 1-2 tabs every 4-6 hours as needed for pain and fever.

_____ Ibuprofen 200 mg: 1-2 tabs every 4 – 6 hours as needed for fever, pain, or inflammation.

_____ Antacid Tablets (Tums): 2 tabs every 4-6 hours for stomach upset.

_____ Chloraseptic Throat Spray: 1 spray every 4-6 hours as needed for sore throat.

_____ Cough Drop: 1 cough drop every 4-6 hours as needed for cough.

_____ Benadryl 25 mg: 1 tab every 4-6 hours as needed for itchy skin due to insect bite, hives, and other causes.

I request that school personnel administer the medication(s) that are checked to my child during school hours should he/she need it. I have noted any special instructions above.

Parent/Guardian Signature: _____ **Date:** _____

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Medications from Home

Indiana Law IC 34.4-16.5 3.5 of Indiana Tort Claims Act allows the school nurse or other designated school personnel to assist students who are required to take medications during the school day. This service is provided to enable the student to remain in school and to maintain or improve the potential for learning.

Student Name: _____ **Grade:** _____

Name of Medication: _____ **Expiration Date:** _____

Dose: _____ **Directions:** _____

Reason for Medication: _____

Special Instructions: _____

All prescription medications must be in the original container, non-expired, and have a prescription label with child's name, medication, dose, and directions.

It is necessary for the above medication to be taken during the school day. Therefore, I request that school staff members administer the medication to my child during the school day in accordance with the above written instructions. I also give my child permission to transport his/her medication to Benton Central Jr/Sr High School. At the end of the school year or sooner, all medications will be returned to the student and should be taken home.

Parent/Guardian Signature: _____ **Date:** _____

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