OEISD

HEALTH INFORMATION

Local ID# _____

OEISD Campus

PK MILITARY ☐

PLEASE PRINT

Date: _____

Name of Student: _____

Grade: _____ Birth Date: _____

Has your child ever been enrolled in Odem-Edroy ISD? _____

Please list any illnesses, injuries, operations or hospitalizations (mental/medical) your child has encountered: (examples: asthma, seizures, tubes, etc.)

_____

_____

List any medications taken daily or on a regular basis: _____

_____

Allergies to food or medicines: _____

Other children in the home (please list with date of birth):

_____ _____

_____ _____

I give my permission for Odem-Edroy ISD employees to give my child the following checked medications during school hours if needed. Please check the following items your child can use. If you want your child to have access to things like Tylenol and Tums you have to provide the age appropriate medication, in the original container, with signed consent.

_____ Eye saline eyewash
_____ Peppermint/sugar free peppermint
_____ White Petrolatum (chapped lips)
_____ Unscented hand lotion
_____ Sting Ease stick

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Phone Number Cell Phone Number

_____ _____
Work Phone Number Other Phone Number