

STUDENT HEALTH INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN EACH SCHOOL YEAR

PART 1:

Student Name:	Last	First	Middle	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Grade	Teacher			DOB / /
Student physician or medical provider				Phone #

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day. Contact the school nurse or our website to obtain Medication Authorization Forms and other procedure forms listed.

ALLERGIES (Allergy Action Plan May be required)

Currently under medical care for allergies YES NO

Physician Name & Phone # _____

Allergy type: **severe**=hives, breathing problems, etc. **mild**=nausea, rash, etc.

Food severe mild List food(s) _____

Medication severe mild List medications(s) _____

Bee/Insect Sting severe mild List _____

Other severe mild List _____

Reactions:

Coughing Hives Rash

Difficulty Breathing Nausea Wheezing

Generalized Swelling Local Swelling Other

Currently Prescribed Treatments: Oral antihistamine (Benedryl, etc.) Require EPI-PEN Other _____

ASTHMA (Asthma Action Plan may be required)

Currently under medical care for asthma? YES NO

Physician name/phone# _____

Currently Prescribed treatments: Inhaler Nebulizer Peak Flow Monitoring Oral antihistamines

Triggers: Exercise Environmental Other _____

Date of last hospitalization related to asthma _____

DIABETES **TYPE I** **TYPE II** (Diabetic Care Plan may be required)

Currently under medical care for diabetes? YES NO

Physician name & phone number _____

Currently prescribed treatment: Insulin Syringe Pen Pump Glucagon Blood Testing

Oral Medication(s) List _____

SEIZURE DISORDER (Seizure Action Plan may be required)

Currently under medical care for seizures? YES NO

Physician name & phone # _____

Type of seizure: Absence (staring, unresponsive) Complex partial Generalized tonic-clonic (grand mal, convulsive)

Other (explain) _____

Date of last seizure _____ Length of seizure _____

Needed at School

Medication(s) List _____ YES NO

_____ YES NO

CONTINUE ON REVERSE

OTHER CONDITIONS

Currently under medical care? YES NO

Physician name & phone # _____

CANCER HEART (circulatory) LUNG BLOOD KIDNEY (urinary)

PHYSICAL DISABILITY CEREBRAL PALSY ADD/ADHD FAINTING HEADACHES

Explain (be specific) _____

Medication needed at school? YES NO Explain/List _____

Special Procedures (i.e.: catheter, cardiac monitor, etc.) _____

VISION CONDITIONS CURRENTLY under medical care for vision conditions? YES NO

Contacts Glasses Other (explain) _____

HEARING CONDITIONS Currently under medical care for hearing conditions YES NO

Hearing Aids Cochlear implants other (explain) _____

ADDITIONAL INFORMATION

Please list any additional information you feel may be helpful while he/she is at school.

PART 3:

INSURANCE INFORMATION

1. Is your child covered by a Health Insurance Program? YES NO

2. Would you like information sent home about a State Health Insurance Plan? YES NO

PART 4:

EMERGENCY AUTHORIZATION and SHARING OF INFORMATION

Please read carefully, complete, and sign.

In case of an emergency, and I can not immediately be reached, I do authorize officials of Greene County Public Schools to contact any persons previously named by me. It is **MY** responsibility to ensure the school has all necessary emergency contact information.

I **DO** **DO NOT** authorize officials of Greene County Public Schools and the physician(s) listed to discuss medical condition(s), treatments(s), concerns, etc. as necessary for the health of my child.

In the event physicians, parent/guardian, or other persons named by me cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of my child. I will not hold the school district financially responsible for the emergency care and/or transportation for my child.

I **DO** **DO NOT** authorize the school nurse to share this health information with my child's teachers, bus drivers, and other appropriate school staff that may be responsible for the care of my child during the school day.

Signature of Parent/Guardian

Date

PLEASE RETURN COMPLETED FORM TO SCHOOL TOMORROW