# STUDENT HEALTH INFORMATION

**(Parent/Guardian to complete both sides)**

| Child's Name | Grade / Bus # | Homeroom Teacher | Date of Birth |
|---|---|---|---|
| | / | | |
| Mother's/Guardian Name | Home # | Work # | Cell # |
| | | | |
| Father's/Guardian Name | Home # | Work # | Cell # |
| | | | |
| Emergency Contact (other than parent) | Home # | Work # | Cell # |
| | | | |

| Physician | Office # | **Pease circle the type of health coverage your child currently receives.** |
|---|---|---|
| | | |
| Dentist | Office # | **Uninsured** |
| | | **Medicaid/Health Choice** |
| Specialist | Office # | **Private Insurance** |
| | | |

**I/We give the school nurse permission to contact me by email for non-emergency correspondence pertaining to my child that may contain medical information.**

_____ _____

**Parent Signature** **Email Address**

## PLEASE READ CAREFULLY AND SIGN BELOW

The nurse works to promote good health among students and staff. Our goal is to help your child have a healthy, successful school year. The Watauga County Board of Education recognizes the interdependence of health and learning.

Therefore, in order to assure optimal student performance at school, height, weight, vision, hearing, and dental screenings will be conducted on a regular basis. Referrals to appropriate health care providers will be made for students needing further evaluation.

The school nurse has guidelines to follow for the care of students on campus. Medications will be given according to the doctor's written direction with parent permission. The nurse does **not** have a supply of over-the counter medications such as Tylenol, ointments, etc., to give to students. Students with life threatening allergies to bee stings, foods or latex will need his/her doctor to provide a written authorization for the injectable medicine (Epi-Pen) to be stored at school. However, should a student have a sudden, undiagnosed, serious life-threatening reaction (anaphylaxis), 911 and the parent/guardian will be notified.

In order to provide optimal care for my child, I/We authorize the school nurse to communicate with the health care providers listed above as allowed by HIPAA.

**Make certain that you notify us of all phone number changes including your child's emergency contact person. Please contact the school nurse if you have any questions.**

_____ _____

Signature of parent/guardian Date

**SCHOOL NURSE USE ONLY**

☐ Medication Authorization Form To Parent

_____

RN Signature/Date

☐ Diet Order Form to Parent

_____

RN Signature/Date

☐ Follow Up Completed

_____

RN Signature/Date

☐ EAP Posted

_____

RN Signature/Date

**PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM BEFORE RETURNING**

# Student Health Information

**(Parent/Guardian to complete both sides)**

Below please check any chronic conditions that your child has, list medications taken and answer the related questions. This information may be shared by the school nurse with school staff as needed to best serve your child while at school.

| **Student:** | |
|---|---|
| **Does your child have any diagnosed medical conditions/needs? If yes, please list below.** | ☐ Yes ☐ No |

| **Chronic Condition** | **√ If Yes** | **List Medications/Time** | **Describe** |
|---|---|---|---|
| ADD/ADHD | | | |
| Allergies (Severe) | | | To what? Type of reaction: |
| Asthma | | | Date of Last Episode:<br>Known triggers: |
| Autistic disorders (ASD) | | | |
| Blood Disorders | | | Type: |
| Cancer | | | Type: Treatment or In Remission Since: |
| Cardiac Condition | | | Specify: |
| Cerebral Palsy | | | Walking Aid: |
| Chromosomal Condition | | | Type: |
| Cystic Fibrosis | | | |
| Diabetes | | | Type I (Pump or Injection) Type II |
| Eating Disorders | | | Specify: |
| Emotional/behavior/and/or psychiatric disorder | | | Specify: |
| Fetal Alcohol Syndrome | | | |
| Stomach Problems (Crohn's, celiac, IBS, encopresis) | | | Specify |
| Hearing Loss | | | Hearing Aid Worn: L R Cochlear Implant: Yes No |
| Frequent Ear Infections | | | Tubes? Yes or No |
| Hemophilia | | | |
| Hydrocephalus | | | |
| Hypertension | | | |
| Hypo/Hyperthyroidism | | | |
| Metabolic/Endocrine Disorders | | | Specify: |
| Migraine Headaches | | | Trigger: |
| Multiple Sclerosis | | | Walking Aid: |
| Muscular Dystrophy | | | Walking Aid: |
| Nosebleeds | | | Frequency: |
| Orthopedic Disability | | | Specify: Walking Aid: |
| Other neurological conditions | | | Specify: |
| Other Neuromuscular | | | Specify: |
| Renal/Adrenal/Kidney | | | Specify: |
| Rheumatological conditions including Lupus and arthritis | | | Specify:<br>Walking Aid: |
| Seizure Disorder | | | |
| Sickle Cell | | | Anemia or Trait |
| Skin Problems | | | Last Seizure: |
| Spina Bifida | | | |
| Traumatic Brian Injury | | | |
| Vision Problems | | Glasses or Contact Lenses | Reading Only or For all school work |
| Other | | | |

Do you request an Emergency Healthcare Plan for any life threatening conditions listed above? ☐ Yes ☐ No

Will your child need to take medication during the school day? ☐ Yes ☐ No

This includes prescription and/or over-the-counter medication. Medications will be given according to the doctor's written direction with parent permission on a Medication Authorization Form

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