2024-2025 STUDENT HEALTH INFORMATION

(Parent/Guardian to complete)

Please check items below that pertain to your child's health, list medications taken and answer the related questions. This information will be in the health room (school nurse) and will be shared with faculty if necessary to best serve your child while at school.

Student Name:		**Date of Birth:**
Homeroom Teacher:		**Grade:**

☐ **My child has NO health problems. _____Initials**

Will your child need to take medication during the school day? ☐ Yes ☐ No (includes Inhaler, Epi-Pen, Valtoco, Diastat & Glucagon)

If **YES,** please see the medication policy in the parent handbook and contact the school nurse to request a medication authorization form.

Chronic Condition	✓ if Yes	Information on Condition	Description for school nurse
ADD/ADHD		ADD/ADHD Medication at home☐ or at School ☐	Name of medication: _____
Allergies:		☐Seasonal ☐ Food ☐ Environmental ☐Other _____	Has the allergy been diagnosed by a physician? Y/N Has your child had to use a epi pen? Y/N Has your Child ever had an anaphylactic reation? Y/N
Autism		☐ Asperger Disorder ☐ Other:_____	Medication: Yes ☐ No ☐
Cancer		Type:	☐ Undergoing treatment ☐ in remission
Diabetic		Type: ☐ I ☐ II	☐Pills ☐ Insulin ☐ Pump ☐ Injection
Down's Syndrome			
Head			
Seizures		☐Epilepsy ☐ Febrile ☐ Other: _____ Date of last seizure_____	Medication_____ Emergency Medicine - Yes ☐ No ☐
Injury/Concussion History		Concussion ☐ Other ☐: _____	Date of Injury/concussion: _____
Headache/Migraines		Medication: Yes ☐ No ☐	Frequency_____
Psychological Disorder _____		Medication: Yes ☐ No ☐	Therapist Yes ☐ No ☐ Name: _____
Dermatology			
Skin problems:		☐Eczema ☐ abnormal skin pigmentations (café-au-lait) ☐hemangiomas ☐ mongolian spots ☐Other:_____	
Vision/Hearing			
Hearing Problems		Hearing Aid Worn: Left ☐ Right ☐ Cochlear Implant: Yes ☐ No ☐	
Vision Problems		Wears: Glasses☐ Contacts ☐ Reading Only ☐ or ALL school work ☐	Date of last eye exam: _____ Provider_____
Circulatory/Respiratory			
Asthma		Medication: Yes ☐ No ☐	Date of last episode: _____ Know Triggers: _____
Cystic Fibrosis		Enzymes: _____	Medication/treatment: _____
Heart Condition/High Blood Pressure		Medication: Yes ☐ No ☐	Specialist: _____
Blood Disorders		☐ Hemophilia ☐ Nosebleeds ☐ Sickle Cell ☐ Other_____	Nosebleed Frequency: _____
Abdominal			
Kidney/Bladder Problems			Specify: _____
Menstrual Problems			Specify: _____
Stomach Problems			
Musculoskeletal (Check if applies)			
☐ Arthritis ☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Spina Bifida ☐Other Orthopedic Problems:_____		☐ Diagnosis: _____ Medication: Yes ☐ No ☐	Walking Aid/Braces: Yes ☐ No ☐ ☐ Wheelchair

Other Health problems not listed:

If your child has a health condition, please contact the school nurse to set up a plan of care to meet your child's needs during the school day.

**** COMPLETE THE REVERSE PAGE BEFORE RETURNING****

STUDENT HEALTH INFORMATION 2024-2025

AN IMPORTANT MESSAGE REGARDING YOUR CHILD'S HEALTH

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 school nurse has guidelines to follow for the care of students on campus. The school nurse is available for first aid/assessment of student. If your child needs to be picked up from school due to illness or concern identified on assessment, you will be notified of their need for follow-up. Medications (inculding emergency medications (epi/inhalers/seizure/glucagon) will be given according to the doctor's written directions with parent permission. The nurse does not have a supply of over-the-counter medications to give to students. However, should a student have a sudden, undiagnosed, serious life-threatening reaction (anaphylaxis), 911 and the parent/guardian listed below will be notified and if needed a trained employee will administer an initial injectable dose of epinephrine.

Child's Name	Grade	Homeroom	Date of Birth

Mother's Name	Current Home Phone	Work Phone	Cell Phone

Father's Name	Current Home Phone	Work Phone	Cell Phone

Parent e-mail address	

Emergency Contact	Current Home Phone	Work Phone	Cell Phone

Physician/Primary Care Provider	Office Phone Number
Dentist	**Office Phone Number**
Specialist	**Office Phone Number**

Has your child ever attended a North Carolina Public School?	YES □	NO □
Does your child have a IEP or 504?	YES □	NO □
Has your child received childhood immunizations?	YES □	NO □
Has your child seen the doctor for a well child check/physical in the last 12 months?	YES □	NO □
Does your child have health insurance (private insurance/medicaid/other)?	YES □	NO □
I give my permission to the school nurse and/or teacher/Faculty/and or Counselor to share or receive health-related information needed to care for my child with the providers listed above during the school year.	YES □	NO □
My Child may participate in screenings listed in the student handbook. You will be notified of any abnormal findings of screenings.	YES □	NO □
Health Screening information will be documented on the health card and/or in the health module of PowerSchool. PowerSchool will also be used to notify school staff of medical alert listed on reverse side.		

I/We do further authorize any physician or hospital to render medical care and treatment in event of an <u>emergency</u> that may be needed to care for my child without our specific permission or authorization. Parent/Guardian: If there are any specific considerations that should be taken into account before rendering medical care or treatment, please complete a statement of explanation.

If you have any changes to any of the above phone numbers or contact's for your child, you are to notify the school.

/

Parent/Guardian signature / Date

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