***2019-2020 GSL Emergency Student Health Information Survey***

 *\*Please return to your child’s school health office as soon as possible.*

***Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Emergency Contacts (include parents/guardians)  | Relationship | Home Phone  | Cell Phone  | Work Phone  | Email  |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

***Section 1: No Health Problems* \_\_\_\_\_\_**

***Section 2: Serious Health Concerns—check all that apply***
\_\_\_Asthma
\_\_\_Diabetes
\_\_\_Severe allergy Allergic to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_Seizures Type of seizure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_Other Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Section 3: Medication – check all that apply***
\_\_\_Insulin/glucagon \_\_\_Student carries \_\_\_Located in school health office \_\_\_not needed at school

\_\_\_Insulin pump \_\_\_Student carries \_\_\_Located in school health office \_\_\_not needed at school
\_\_\_Inhaler \_\_\_Student carries \_\_\_Located in school health office \_\_\_not needed at school
\_\_\_Epi-Pen \_\_\_Student carries \_\_\_Located in school health office \_\_\_not needed at school
\_\_\_Diastat \_\_\_Located in school health office \_\_\_not needed at school
\_\_\_Medication Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_
 \_\_\_Medication has been provided to school \_\_\_Medication **not** needed at school

*\*A medication administration form, with physician orders, must be completed each year in order for the*

*health office to administer any medications to your child.*

***Section 4: Release of Information***

I understand that by signing below this authorizes the LSN or health assistant in the building my student attends to contact my physician regarding this plan. The nurse will also provide a copy of this plan to appropriate school personnel as is necessary for my child’s safety and well-being. I understand that health services are available to my child during the academic school day only, not before or after. I will also keep the school district updated of any changes to this plan or contact information.

***Parent/Guardian Signature*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Date***\_\_\_\_\_\_\_\_\_\_