***ANNUAL 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  |
| PLEASE make sure your child’s Infinite Campus profile has accurate information for names and numbers of emergency contacts. The Information on Infinite Campus is what we will use in the case of an emergency  |

***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***\_\_\_\_\_\_\_\_\_\_