

# SCHOOL HEALTH INFORMATION

Student Name \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Grade/Teacher/Track \_\_\_\_\_

Special Ed Learning Center

Special Ed Functional Skills

**NO HEALTH CONCERN**

Do you feel your student needs a plan of care (helps guide faculty and staff in meeting the needs of your student) on file at the school?

Yes  No

## HEALTH CONCERN(S):

Allergy to: \_\_\_\_\_ EPI-PEN \_\_\_\_\_ Benadryl \_\_\_\_\_

Seizure \_\_\_\_\_ Diabetes \_\_\_\_\_ Glucagon at school \_\_\_\_\_

Asthma \_\_\_\_\_ Inhaler with student \_\_\_\_\_ Inhaler in office \_\_\_\_\_

Other \_\_\_\_\_  
\_\_\_\_\_

Severity of Condition: (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

Medications needed at school?  YES  NO

Name of Medication/s: \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_  
\_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

How to manage health concern/s at school:

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## INFORMED CONSENT

I understand that my student's health information will need to be shared:

1. To benefit the student in terms of health maintenance and academic progress
2. When necessary to accommodate the safety and well being of students and staff
3. With the discretion of the School Nurse to determine what is shared and who should know

I understand that consent for sharing of health information will remain in effect as long as student is enrolled in Davis School District and may be revoked at anytime in writing by parent/guardian.

I understand if clarification of the health information is needed that my signature:

1. Authorizes the School Nurse to contact the medical provider
2. Authorizes the medical provider to release information

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_