Cherokee County School District

STUDENT HEALTH NEEDS IDENTIFICATION FORM

THIS FORM IS TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN AND RETURNED TO THE SCHOOL NURSE

STUDENT'S NAME_____ DOB_____

SCHOOL_____ GRADE_____

1. MY CHILD HAS NO KNOWN MEDICAL CONDITIONS.

PARENT/GUARDIAN SIGNATURE_____DATE_____

IF NO MEDICAL CONDITIONS INDICATED YOU MAY STOP HERE. ***IF YOUR CHILD HAS MEDICAL CONDITIONS THE SCHOOL NURSE NEEDS TO BE MADE AWARE FILL OUT SECTION #2 BELOW.***

2. THE SCHOOL SHOULD BE AWARE OF THE MEDICAL CONDITIONS INDICATED BELOW.

Asthma treated with daily medication		Nosebleeds	
Diabetes		Respiratory problems	
Seizures/Epilepsy		Cancer	
Heart Problems		Kidney problems	
Headaches		Blood disorders	
Skin diseases		Other:	
*Allergies (See below)		Other:	

*If yes to allergies, please list: _____

Has your child experienced an anaphylactic reaction in the past (including, but not limited to, difficulty breathing or shock?) Yes No

Has an emergency epinephrine injector been used on your child due to an anaphylactic reaction? Yes No

PARENT/GUARDIAN SIGNATURE_____DATE_____