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_____ D.O.B. _____

SCHOOL _____ GRADE _____

HOMEROOM TEACHER _____ TEAM _____

SIBLING(S) ENROLLED IN CCSD:

Name _____ Grade _____ School _____

Name _____ Grade _____ School _____

Name _____ Grade _____ School _____

PARENT/LEGAL GUARDIAN _____

PHONE NUMBERS:
HOME _____ CELL _____ WORK _____

PHYSICIAN _____ PHYSICIAN'S PHONE No._____

Is your child allergic to any medications? ☐ YES ☐ No If yes, please list_____

MEDICAL HISTORY: PLEASE CHECK BELOW IF YOUR CHILD HAS NOW OR HAS HAD IN THE PAST:

	NOW	PAST		NOW	PAST
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:		

Please describe other medical problems: _____

Does your child have any physical, hearing or visual disability? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have a medical procedure that must be performed during the school day? ☐ Yes ☐ No

If yes, please list: _____

*Does your child have allergies to food or insects? ☐ Yes ☐ No

If yes, 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

If yes, please describe the circumstances: _____

List any medications your child is taking that the school nurse and/or staff should be aware of:

_____

The school cannot administer any medication until a medication authorization form has been completed for <u>each</u> medication. Medication must be provided by a parent/legal guardian.

_____ _____

Parent/Legal Guardian Signature Date