STAFFORD COUNTY PUBLIC SCHOOLS HEALTH SERVICES

SCHOOL HEALTH INFORMATION FORM

Name: _____ **Birth date: Mo.** ____ **Day** ____ **Yr.** _____
Last **First** **Middle Name**
Sex: Male ☐ **Female** ☐
Parent or Guardian _____ **Work Phone:** _____
Last **First** **Home Phone:** _____
Home Address: _____ _____ **Zip:** _____
Person to call in case of an emergency if parent/guardian is not available:
Name: _____ **Phone:** _____

Please provide information relative to the following health concerns of your child and return to office.

☐ yes ☐ no	**Allergies: type** _____	☐ yes ☐ no	**Heart Disease**
☐ yes ☐ no	**Asthma**	☐ yes ☐ no	**Thyroid Disease**
☐ yes ☐ no	**Cancer : type**_____	☐ yes ☐ no	**Mental Health**
☐ yes ☐ no	**Cerebral Palsy**	☐ yes ☐ no	**Stomach/Intestine**
☐ yes ☐ no	**Ear/Nose/Throat**	☐ yes ☐ no	**Elimination (bowel or urination)**
☐ yes ☐ no	**Diabetes: type**_____		
☐ yes ☐ no	**Eye/Vision**	☐ yes ☐ no	**Seizure Disorder**
☐ yes ☐ no	**ADHD**	☐ yes ☐ no	**Spinal Disorder/Injury**
☐ yes ☐ no	**Hearing**	☐ yes ☐ no	**Other**

If yes to any of the above, describe condition and equipment necessary, also list and describe any condition not listed above.

_____
_____
_____

Surgical History

Describe any hospitalizations/surgeries/fractures:

_____
_____
_____
_____

Medications

<u>LIST ALL</u> PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TAKEN AT HOME AND SCHOOL. A separate permission form is required in order for medications to be given at school.

_____
_____
_____
_____

I consent to the release of this health information concerning my student ,_____ ,
to any Stafford County Public School staff who need to know this information for health and safety reasons when they are working with my student at school.

Parent/Guardian Signature _____**Date** _____