



6675 EAST HIGHWAY 16  
 SENOIA, GA 30276  
 Tel: 770-727-5959  
 Fax: 770-727-5949  
[cowetacharteracademy.org](http://cowetacharteracademy.org)  
 \*Confidential

**STUDENT HEALTH INFORMATION 2025-2026 SY**

Student Name \_\_\_\_\_ M / F \_\_\_\_\_ DOB \_\_\_\_\_

Parent/Guardian (print) \_\_\_\_\_ Best contact #: \_\_\_\_\_

Please fill out the following information so we can better care for your child if they have needs during the school day. Some examples include asthma, allergies, epilepsy, anxiety, diabetes, migraines, seizures, previous medical conditions that may recur, etc.

\*If your child has a chronic condition that requires ongoing care and/or medication (Allergies requiring an Epi-Pen, Asthma, Diabetes, or Seizure Disorder) please have your child’s physician fill out an Action Plan specific to your child and their condition in addition to this form\*

Please circle Yes or No:

- Y    N    Allergies \*explain below (please include environmental, foods, medications, insects, etc.)
- Y    N    History of **Anaphylaxis**
- Y    N    Uses Epi-Pen or Epi-Pen Jr. (please circle one)
- Y    N    Will Epi-Pen/Epi-Pen Jr. be stored in the Clinic for this student?
- Y    N    Will your student self-carry own Epi-Pen? (If yes, please fill out self-carry authorization form)

My child is allergic to:

The allergic response is:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Action/Intervention needed (please specify) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

- Y    N    **Asthma** \*please attach a copy of **Action Plan** from your Provider
- Y    N    **Diabetes** \*please specify either type I or type II  
 \*Please attach a copy of **Action Plan** from your Provider
- Y    N    **Seizure disorder** \*please specify and attach **Action Plan** from your Provider\*

\_\_\_\_\_  
 \_\_\_\_\_

Other condition:

Would you like to share any other information about your child?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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Student Name \_\_\_\_\_ M / F \_\_\_\_\_ DOB \_\_\_\_\_

Does your child wear any corrective equipment such as glasses, contact lenses, AFO's, hearing aids, prostheses, etc.? Please explain:

\_\_\_\_\_
\_\_\_\_\_

Please circle Yes or No:

Y N My child takes daily medication(s)
List of medications \_\_\_\_\_

Y N My child will need medication during the school day
If yes, please list: \_\_\_\_\_

Any medication that needs to be given to students during the school day requires a Medication Authorization Form signed by parent/guardian prior to administering.
The Medication Authorization Form may be downloaded from the school website or obtained from the office or school nurse. Medication is to be delivered in person by the parent/guardian only.
Please sign below that you have read and understand the above statement.
Signature of Parent/Guardian Date
Printed Name of Parent/Guardian

Some over-the-counter topical medications are available in the school clinic for basic first aid and student comfort. Please read the following list of available products that may or may not be used on your child at the discretion of the school nurse. If you do not wish these products to be used on your child, you must notify the nurse.

Aquaphor, benzocaine spray, bacitracin/Neosporin, cortisone cream, cough drops, dental wax, isopropyl alcohol pad, first aid antiseptic.

Please indicate below if you do not wish these products to be used on your child.

I do not want these over-the-counter medications given to my child.
Signature of Parent/Guardian \_\_\_\_\_
Printed Name of Parent/Guardian \_\_\_\_\_



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