Bus No:_____ # SCHOOL NURSE HEALTH INFORMATION FORM

Year_____ Grade_____ Teacher _____ Home School _____

Name:_____ Birthdate:_____ Gender: ☐Male ☐Female Weight_____
(Last) (First) (MI)

Please list parent/guardian by first contact preference.

1. Parent or Legal Guardian:_____ E-mail:_____

   Contact Phone: Home: _____ Work:_____ Cell:_____

2. Parent or Legal Guardian:_____ E-mail:_____

   Contact Phone: Home: _____ Work:_____ Cell:_____

Home Address:_____ Zip Code:_____

Emergency Contact:

(1) Name:_____ Relationship:_____ Phone:_____

(2) Name:_____ Relationship:_____ Phone: _____

(3) Name:_____ Relationship:_____ Phone: _____

** The emergency contact may release my child from school for medical reasons if the parent/guardian cannot be reached.

Physician:_____ Phone:_____

Dentist: _____ Phone: _____

Health Insurance: ☐Private ☐Medicaid ☐FAMIS ☐None Do you need assistance obtaining medical insurance? ☐Yes ☐No

** Roanoke County Public Schools is authorized to release or exchange information during the present school year with the Health Department and the following physician or agency:_____

Preferred hospital in the event of an emergency:_____. Do you give the School permission to call the doctor or send the child to the hospital in the event you cannot be located? ☐Yes ☐No

Medications

Prescription Drugs: Identify drug(s) and **condition requiring its use**. _____

_____

Over-the-Counter Drugs (Nonprescription): Identify drug(s) and reason for use. _____

_____

Drug Allergies: List and describe reaction when taken. _____

_____

When a **school nurse** is available to assess the needs of the student, I give my permission for the following over-the-counter medication to be given (check yes or no). **Over-the-counter medications are for occasional use only. School staff may not administer these medications.**

< Tylenol (Acetaminophen) ☐ Yes ☐ No

< Advil (Ibuprofen) ☐ Yes ☐ No

< Antacid (Tums or generic chewable tablets) ☐ Yes ☐ No

< Benadryl Elixir (Diphenhydramine) ☐ Yes ☐ No
Benadryl is given only for an allergic reaction, NOT seasonal allergies

< Antibiotic Ointment ☐ Yes ☐ No

< Benadryl Ointment (Diphenhydramine) ☐ Yes ☐ No

< Caladryl Cream/Lotion (Calamine) ☐ Yes ☐ No

- PLEASE COMPLETE INFORMATION ON REVERSE SIDE –

Acute or Chronic Illnesses (Check all that apply.)

- ☐ ADD – Medication_____ ☐NONE
- ☐ ADHD – Medication_____ ☐NONE
- ☐ Adrenal Insufficiency
- ☐ Anemia
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Chickenpox If yes, when_____
- ☐ Cystic Fibrosis
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Scoliosis
- ☐ Sickle Cell Anemia
- ☐ Spina Bifida
- ☐ Wear Glasses? ☐ Contacts?

☐ Allergies: ☐Food ☐Environmental ☐Seasonal Describe:_____
Needs Epi-Pen at school? ☐Yes ☐No (If yes, please provide Epi-Pen and Anaphylaxis Emergency Action Plan to school nurse)

☐ Asthma: Needs an inhaler at school? ☐Yes ☐No (If yes, please provide inhaler and Asthma Action Plan to school nurse)

☐ Cancer: If yes, describe. _____

☐ Diabetic: Insulin at school? ☐Yes ☐No Pump? ☐Yes ☐No Type _____
Glucagon at school? ☐Yes ☐No CGM? ☐Yes ☐No

☐ Fractures: If yes, describe. _____

☐ Gastrointestinal Problems: If yes, describe._____

☐ Headaches or Migraines (circle one): Followed by a physician for this? ☐Yes ☐No

☐ Hearing difficulty: If yes, explain._____ Use hearing aid? ☐Yes ☐No

☐ Heart Disease: If yes, describe._____

☐ Menstrual Problems: If yes, describe._____ Prescription medication? ☐Yes ☐No

☐ Seizures: If yes, describe. _____

List All Surgeries

_____

_____

Orthopedic Devices

- ☐ Wheelchair
- ☐ Crutches
- ☐ Braces (arms/legs/back)

Other:_____

Please indicate any other health condition(s) your child has that is/are not covered on this form. _____

_____

_____

Does your child have a 504 Plan? ☐Yes ☐No An IEP? ☐Yes ☐No

Please indicate any special medical considerations needed for your child. _____

_____

_____

I/We understand that this information may be shared with certain school staff as deemed necessary to ensure the safety and health of the student.

_____
(Parent/Guardian Signature)

_____
(Date)