Last School Attended ____

Rosewood Elementary School

2025-2026
Richland County School District One

CONFIDENTIAL HEALTH QUESTIONNAIRE FOR SCHOOL NURSE ONLY

STUDENT NAME__________________________________ BIRTHDATE _____/____/______

MALE ☐ FEMALE ☐ RACE_________ GRADE ______ HOMEROOM TEACHER _________________

ADDRESS____
ZIP CODE______________ HOME PHONE_____________________________

STUDENT LIVES WITH (CIRCLE ONE): MOTHER FATHER BOTH PARENTS OTHER________________

MOTHER/ LEGAL GUARDIAN'S NAME __________________________________EMPLOYER ___________________
WORK NUMBER_______________ CELL PHONE__________________ E-MAIL _____________________________

FATHER/ LEGAL GUARDIAN'S NAME __________________________________EMPLOYER ___________________
WORK NUMBER_______________ CELL PHONE__________________ E-MAIL _____________________________

STEP PARENT (living with child) NAME _______________________________ PHONE # ______________________

LIST THE NAME(S) OF ANY SIBLINGS AT PRESENT SCHOOL: ____

HEALTH CARE PROVIDER/NURSE PRACTITIONER____
TELEPHONE NUMBER__________________LAST PHYSICAL/VISIT _______________________________________
DENTAL CARE PROVIDER____
TELEPHONE NUMBER __________LAST VISIT ___________ (RECOMMENDED CLEANING EVERY 6 MONTHS)
MEDICAID (CIRCLE ONE) Y / N POLICY NUMBER______________________________________
PREFERRED HOSPITAL____

LIST 2 AUTHORIZED PEOPLE TO ASSUME RESPONSIBILITY AND PICK UP YOUR CHILD IN CASE OF AN ILLNESS/EMERGENCY WHEN THE PARENT/GUARDIAN CANNOT BE REACHED

1. NAME ______________________________________RELATIONSHIP TO STUDENT _______________________
   PHONE NUMBER (WORK)___________________(HOME)____________________(CELL)__________________
   ADDRESS____

2. NAME ______________________________________RELATIONSHIP TO STUDENT _______________________
   PHONE NUMBER (WORK)___________________(HOME)____________________(CELL)__________________
   ADDRESS____

(PLEASE COMPLETE THE BACK OF THIS FORM)

For School Nurse Only:

Reviewed By: __________________Date: ______________ School Year: _____________

Revised 5/2014

Please check (√) and explain any health conditions DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER (Doctor or Nurse Practitioner)

Check	Condition	Explain
	ADD/ADHD	(CURRENT MEDICATION):
	ALLERGIES SEVERE REQUIRING AN EPI-PEN (Extra should be kept at school)	☐ Food: ☐ Insects: ☐ Seasonal:
	ANEMIA (LOW BLOOD)	
	ASTHMA (Inhaler should be available at school with completed medication forms on file)	Medication: Last Attack: ____/___/______
	BLADDER/URINARYCONDITION	
	BONE/ORTHOPEDIC CONDITION	
	DIABETES (SUGAR)	Medication:
	EPILEPSY(SEIZURES)	Last Episode: ____/___/______ Medication:
	FAINTING SPELLS (Syncope)	
	GENETIC CONDITION	
	HEART TROUBLE	Corrected: Y / N
	HEMOPHILIA/BLEEDING DISORDER	
	HIGH BLOOD PRESSURE	
	MENTAL HEALTH ILLNESS	DIAGNOSIS:
	PROBLEMS WITH VISION	GLASSES: Y / N - LAST EXAM: ____/___/______
	PROBLEMS WITH HEARING	HEARING AID: Y / N EAR: ☐ RIGHT ☐ LEFT
	REACTIVE AIRWAY DISEASE	
	SICKLE CELL	Last Crisis: ___/__/____ Last Hospitalization: ___/___/____
	SICKLE CELL TRAIT ONLY	
	SKIN DISORDER	
	TUBERCULOSIS (TB)	
	OTHER:	

Does your child take any daily medications? ☐ No ☐ Yes – List medication and dosage:

____

____

____

Medication given at: ☐ Home ☐ School ☐ Only in Emergency

When possible, the parent/legal guardian should arrange for the student to receive medication before or after school hours.

Medication should be brought to the health room in its original container and the appropriate forms should be completed prior to a student receiving medicine at school. Parental consent is required for non-prescription medication and both parental and student's healthcare provider signatures are required for prescription medication. Students that will self-medicate/carry his or her meds while at school (i.e. albuterol inhaler) should have a "**parental release**" and **"self-medicating and/or self-monitoring"** forms completed by the parent, health care provider and student.

I GIVE THE SCHOOL NURSE PERMISSION TO CONTACT THE LICENSED PRESCRIBER AND/OR SHARE THE ABOVE INFORMATION WITH SCHOOL STAFF AND DISTRICT STAFF AS NECESSARY FOR MEETING MY CHILD'S EDUCATIONAL NEEDS.

PARENT/ LEGAL GUARDIAN'S SIGNATURE __________________________________DATE _____________