STUDENT HEALTH INFORMATION

Parent/Guardian to complete both sides

Student's Name_____ Birthdate _____

Homeroom Teacher and Grade_____

Address _____City and Zip _____

Mother's Name _____Work #_____Cell #_____

Father's Name _____Work #_____Cell #_____

Emergency Contact and Numbers_____

Dentist _____Office #_____

Physician _____Office #_____

Has your child seen the doctor for a well child check-up within the past 12 months?	YES	NO
Does your child have health insurance?	YES	NO
Does your child have Medicaid?	YES	NO
Does your child have Health Choice?	YES	NO

I give permission to the school nurse to share or receive health related information needed to care for my child with the healthcare providers listed above during the school year.
YES NO Parent Signature _____

AN IMPORTANT MESSAGE ABOUT YOUR CHILD'S HEALTH

As you may know, we have a registered nurse, who is employed by the Davidson County Health Department or School System and is assigned to this school. The school nurse works with us to promote good health among our students and staff. Our goal is to help your child have a healthy, successful school year. The school nurse has guidelines to follow for the care of students in our school. Medications will not be given by the school nurse, but by staff that has been instructed on medication administration. For prescribed medication to be administered, a medication permission form must be on file that has been signed by the parent and physician; this includes EPI pens for life-threatening allergies, asthma inhalers, and diabetes medication. The school does not supply over the counter medication such as Tylenol and Benadryl to give to students. If a student needs over the counter medication, the parent must provide this in the original container and sign a medication permission form.

Make certain that you notify us of all phone number changes including your child's emergency contact person. Please contact the school nurse if you have any questions@

School Nurse **Phone Number**

** Please complete the other side before returning to the school**

(Continued from other side)

Student Health Information

Parent/Guardian to complete both sides

Please check any health condition your child may have at this time. When the school nurse receives this form, if medically necessary, an Individualized Health Plan (IHP)/Emergency Action Plan (EAP) will be sent home for you to complete. If your child is on medication, you may provide the name of the medication in the far right column. **Because space is limited, please feel free to attach a note providing further necessary information.** *You may request a copy of the IHP/EAP (medical care plan) at any time during the school year.*

Student _____

Homeroom Teacher Grade

Please check all that apply		Additional Info	Meds
	ADD/ADHD **Please check _____ if not currently on meds or no medications will be given during school hours**		
	Allergies (severe - requiring EPI pens) **What is child allergic to:**		
	Asthma		
	Autism (ASD) Asperger's,PDD		
	Blood disorder,Hemophilia, anemia, Thalassemia		
	Cancer, including leukemia	Remission Y N	
	Cardiac / Heart		
	Cerebral Palsy		
	Chromosome conditions; Down Syndrome, Fragile X, 22Q Deletions, Trisomy 18, etc.		
	Chronic Encopresis		
	Chronic infectious diseases; Toxoplasmosis, CMV, Hepatitis B or C, HIV, TB, etc.		
	Concussion – how many – when Traumatic Brain Injury		
	Cystic Fibrosis		
	Diabetes please circle Type 1 or Type 2		
	Eating disorder; bulimia, anorexia, binge & purge, etc.		
	Emotional, behavioral, or psychiatric not listed elsewhere		
	Fetal Alcohol Syndrome		
	Gastrointestinal disorder; IBS, Crohn's, Celiac Disease, gluten intolerance, GERD,		
	Hearing Loss or vision impairment uncorrectable		
	Hemophilia		
	Hydrocephalus, and or Shunt		
	Hypertension (high blood pressure) or Hypotension (low blood pressure) circle one		
	Hypothyroidism, Hyperthyroidism, Hashimoto's, other		
	Integumentary; skin conditions; eczema, psoriasis, chronic dermatitis, other		
	Metabolic or endocrine disorders not listed		
	Migraines		
	Multiple Sclerosis, Muscular Dystrophy, other not listed		
	Obesity greater than 95th% BMI		
	Orthopedic disability (permanent)		
	Other neurological or neuromuscular disease or condition not listed, TBI		
	Renal (Kidney or bladder) or Adrenal including Addison's		
	Rheumatological Conditions; Lupus, JRA, other		
	Seizure disorder or Epilepsy		
	Sickle Cell Anemia or Sickle Cell Trait		
	Other		

Does your child need to take medication during the school day? YES NO

If yes, parent should complete the medication permission form. If prescribed, the doctor must sign the same form.
Medication Permission Forms may be downloaded from school website or received from school office or teacher.
PLEASE BE SURE TO COMPLETE THE REVERSE SIDE OF THE FORM BEFORE RETURNING

Signature of parent/guardian _____ **Date** _____