

STUDENT HEALTH INFORMATION 2026-2027

AN IMPORTANT MESSAGE REGARDING YOUR CHILD'S HEALTH

The nurse works to promote good health among 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 on campus. The school nurse is available for first aid/assessment of student. If your child needs to be picked up from school due to illness or concern identified on assessment, you will be notified of their need for follow-up. Medications (including emergency medications (epi/inhalers/seizure/glucagon) will be given according to the doctor's written directions with parent permission. The nurse does not have a supply of over-the-counter medications to give to students. However, should a student have a sudden, undiagnosed, serious life-threatening reaction (anaphylaxis), 911 and the parent/guardian listed below will be notified, and if, needed a trained employee will administer an initial injectable dose of epinephrine.

Child's Name	Grade	Homeroom	Date of Birth
Mother's Name	Current Home Phone	Work Phone	Cell Phone
Father's Name	Current Home Phone	Work Phone	Cell Phone
Parent e-mail address			
Emergency Contact	Current Home Phone	Work Phone	Cell Phone
Physician/Primary Care Provider	Office Phone Number		
Dentist	Office Phone Number		
Specialist	Office Phone Number		
Has your child ever attended a North Carolina Public School?			YES ☐ NO ☐
Does your child have an IEP			YES ☐ NO ☐
Does your child have a 504?			YES ☐ NO ☐
Has your child received childhood immunizations?			YES ☐ NO ☐
Has your child seen the doctor for a well child check/physical in the last 12 months?			YES ☐ NO ☐
Does your child have health insurance?			YES ☐ NO ☐
Please circle which insurance: private insurance - medicaid - other			
I give my permission to the school nurse to share or receive health-related information needed to care for my child with the providers listed above during the school year. This information will be shared if indicated to child's teacher/faculty/counselor for the care of your child during the school day.			YES ☐ NO ☐
My child may participate in health screenings for vision/hearing/dental as listed in the student handbook. You will be notified of any abnormal findings of screenings.			YES ☐ NO ☐
Health Screening information will be documented on the health card and/or in the health module of Infinite Campus. If a medical condition is present, a notice will be added to the student's Infinite Campus profile.			
I/We do further authorize any physician or hospital to render medical care and treatment in event of an <u>emergency</u> that may be needed to care for my child without our specific permission or authorization. Parent/Guardian: If there are any specific considerations that should be taken into account before rendering medical care or treatment, please complete a statement of explanation.			
If you have any changes to any of the above phone numbers or contacts for your child, you are to notify the school.			
Parent/Guardian signature		Date	

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(Parent/Guardian to complete)

Please check items below that pertain to your child's health, list medications taken and answer the related questions.

This information is in the health room (school nurse) and will be shared with faculty if necessary to best serve your child while at school.

Student Name:

Date of Birth:

Homeroom Teacher:

Grade:

☐ My child has NO health problems. _____ Initials



Will your child need to take medication during the school day? ☐ Yes ☐ No

(Includes inhaler, epi-pen, valtocho/diastat, glucagon/baqsimi)

If YES, please see the medication policy in the parent handbook and contact the school nurse to request a medication authorization form.

Chronic Condition	☒ if Yes	Information on Condition	Description for school nurse
ADD/ADHD		Taking ADD/ADHD Medication Yes ☐ No ☐ Name of medication: _____	Needs to take medication at school: Yes ☐ No ☐
Allergies:		☐ Seasonal ☐ Environmental ☐ Bees/Insects-requiring treatment	Triggers: for allergies: _____ Has an epi pen for reaction to stings Yes ☐ No ☐
		☐ Food allergies: please list: _____	Has the allergy been diagnosed by a doctor? Yes ☐ No ☐ Diet order in place for cafeteria? Yes ☐ No ☐ Child has epi pen for reactions: Yes ☐ No ☐
Autism		☐ Asperger Disorder ☐ Other: _____	Medication: Yes ☐ No ☐
Cancer		Type: _____	☐ Undergoing treatment ☐ in remission
Diabetic		Type: ☐ I ☐ II	☐ Pills ☐ Insulin ☐ Pump ☐ Injection
Down's Syndrome			

Head

Seizures		☐ Epilepsy ☐ Febrile ☐ Other: _____ Date of last seizure: _____	Medication: _____ Emergency Medicine - Yes ☐ No ☐
Injury/Concussion History		Concussion ☐ Other ☐ : _____	Date of Injury/concussion: _____
Headache/Migraines		Medication: Yes ☐ No ☐	Frequency: _____
Psychological Disorder _____		Medication: Yes ☐ No ☐	Therapist Yes ☐ No ☐ Name: _____

Dermatology

Skin problems:		☐ Eczema ☐ abnormal skin pigmentations (café-au-lait) ☐ hemangiomas ☐ mongolian spots ☐ Other: _____
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Vision/Hearing

Hearing Problems		Hearing Aid Worn: Left ☐ Right ☐ Cochlear Implant: Yes ☐ No ☐
Vision Problems		Wears: Glasses ☐ Contacts ☐ Reading Only ☐ or ALL school work ☐
		Date of last eye exam: _____ Provider: _____

Circulatory/Respiratory

Asthma		Medication: Yes ☐ No ☐	Date of last episode: _____ Know Triggers: _____
Cystic Fibrosis		Enzymes: _____	Medication/treatment: _____
Heart Condition/High Blood Pressure		Medication: Yes ☐ No ☐	Specialist: _____
Blood Disorders		☐ Hemophilia ☐ Nosebleeds ☐ Sickle Cell ☐ Other: _____	Nosebleed Frequency: _____

Abdominal

Kidney/Bladder Problems			Specify: _____
Menstrual Problems			Specify: _____
Stomach Problems			

Musculoskeletal (Check if applies)

☐ Arthritis ☐ Cerebral Palsy	☐ Diagnosis: _____	Walking Aid/Braces: Yes ☐ No ☐
☐ Multiple Sclerosis ☐ Muscular Dystrophy	Medication: Yes ☐ No ☐	☐ Wheelchair
☐ Spina Bifida		
☐ Other Orthopedic Problems: _____		

Other Health problems list here:

If your child has a health condition, please contact the school nurse to discuss a plan of care to meet your child's needs during the school day.

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