



UNION COUNTY PUBLIC SCHOOLS

SCHOOL HEALTH

Dear Parent/Guardian,

I am sending this letter to gather information about students who have health needs. Please fill out the reverse side of this form, "Request for Health Information," regardless of if your student has medical needs that could affect learning or might require emergency care during the school day. A health care provider's written diagnosis is required in order for an Individualized Healthcare Plan to be developed by the school nurse. Also, please let your school nurse know if your child participates in extracurricular school activities.

Chronic Health Conditions

- Please complete the reverse side of this form.
- If your child has a life-threatening condition/allergy, please notify the school nurse and any other staff members who will be in contact with your child (including afterschool care, cafeteria/bus driver/coach/extracurricular activities).
- Contact the school nurse if you need to schedule a conference to discuss details regarding the development of a health care plan for your child.
- Provide necessary changes that occur during the school year, either with contact numbers or your child's health condition.

Medication Administration

- Medication must be sent in the original container if it is an over-the-counter medicine or a prescription bottle if it is a prescription medicine.
- Please check expiration dates. School personnel are not allowed to give expired medications.
- The school does not provide any medications, including ointments, creams, pain relievers, eye drops, etc. Any medication given at school must be provided by the parent/guardian.
- A medication consent form is required for any medication given at school.
- **Signatures from a parent/guardian AND the student's health care provider are required for ANY medication to be given at school. This includes prescription as well as over the counter medications.**
- Faxed consents from parents and/or doctors are acceptable.
- The entire UCPS medication policy may be viewed online at www.ucps.k12.nc.us

If you have questions or concerns, please contact the school. I would be happy to speak with you.

Sincerely,

School Nurse

In compliance with federal law, UCPS administers all educational programs, employment activities and admissions without discrimination against any person on the basis of gender, race, color, religion, national origin, age or disability.



Request for Health Information

Must be completed annually

Date: _____

Please return the following form to your child's teacher as soon as possible. This information will be reviewed by the School Nurse.

School:	Grade:	Homeroom Teacher:
STUDENT NAME:	Date of Birth:	Bus #:
Parent/Guardian:	Daytime Phone (1):	
Parent/Guardian email:	Daytime Phone (2):	
Emergency Contact:	Phone:	
Current Doctor/Practice:	Phone:	
Current Medications:		
Medications needed at school?: ☐ No ☐ Yes* (list): _____		
(*) Medication consent form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received. Consent form will be provided upon request.		

Check the condition(s) your child has below, OR

☐ MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

☐ ADD/ADHD (See Below) ☐ Allergies, Severe (See Below) ☐ Asthma (See Below) ☐ Autism ☐ Cancer/Leukemia Date Diagnosed: _____	☐ Cerebral Palsy ☐ Crohn's Disease/IBS ☐ Cystic Fibrosis ☐ Diabetes (See Below) ☐ Down Syndrome ☐ Epilepsy/Seizures (See Below) ☐ Glasses/Contacts	☐ Hearing Aid/Loss ☐ Concussion Date Diagnosed: _____ ☐ Heart Conditions Type: _____ ☐ Hemophilia/Bleeding Disorder ☐ Mental Health Diagnosis (See Below) ☐ Migraine Headaches	☐ Neuromuscular Disease ☐ Nosebleeds, frequent and/or severe ☐ Orthopedic Impairment ☐ Renal/Kidney Disease ☐ Juvenile Rheumatoid Arthritis ☐ Sickle Cell Anemia ☐ Ulcers/Gastric Reflux ☐ Other: _____
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FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

Severe Allergies Notify your School Nurse IMMEDIATELY If anaphylaxis may occur.	What is your child allergic to? ☐ Peanuts ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Insect Stings ☐ Other: _____ Is medication needed at school for allergies? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* (requires self-carry form) ☐ Health Room Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs: ☐ Hives ☐ Swelling ☐ Difficulty Breathing ☐ Other: _____
Asthma	Is medication needed at school for asthma? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* (requires self-carry form) ☐ Health Room Date of last episode: _____ Check what is likely to cause an asthma flare: Triggers: ☐ Environmental ☐ Seasonal ☐ Exercise induced ☐ Upper respiratory infection ☐ Other: _____
Epilepsy/Seizures	Type: ☐ Convulsive ☐ Non-Convulsive Date of last seizure: _____ Is emergency medication needed at school? ☐ No ☐ Yes* If yes, name: _____
Diabetes	Type I ☐ Type II ☐ Diagnosis Date: _____ * Insulin by: ☐ Pump ☐ Injections CGM (i.e.: Dexcom): ☐ No ☐ Yes, Type: _____ Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed
ADD/ADHD Mental Health	Type: ☐ ADD ☐ ADHD ☐ Anxiety ☐ Depression ☐ Other: _____ Medication(s) used for treatment: _____

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and you cannot be reached, I give permission for the School Nurse to contact my doctor for further instructions on medications or care.

Signature of Parent/Guardian _____

Date _____