



**Student Health Information**

To be completed by Parent/Guardian each school year

**PART I**

<b>Student Name</b>	Last	First	Middle	<input type="checkbox"/> Male <input type="checkbox"/> Female
Grade	Teacher			DOB / /
Student Physician or Medical Provider			Phone	

**PART II – COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD**

**ALLERGIES** (Allergy Action Plan may be required)

**Has your child been diagnosed with an anaphylactic reaction to food(s)**  Yes  No  
 Has your child ever been PRESCRIBED and EPI-PEN  Yes  No  
 Prescriber's Name & Phone \_\_\_\_\_ List Food(s) \_\_\_\_\_  
 Reactions to food  Lungs – breathing wheeze, cough  Mouth – tongue or lips swelling  Skin – hives, rash, local swelling  
 Heart – pale, faint, weak pulse, dizzy  Gut – vomiting, diarrhea, cramping

**Has your child been diagnosed with an anaphylactic reaction to non-food item(s)**  Yes  No  
 Has your child ever been PRESCRIBED and EPI-PEN  Yes  No  
 Prescriber's Name & Phone \_\_\_\_\_ List Item(s) \_\_\_\_\_  
 Reactions to item  Lungs – breathing wheeze, cough  Mouth – tongue or lips swelling  Skin – hives, rash, local swelling  
 Heart – pale, faint, weak pulse, dizzy  Gut – vomiting, diarrhea, cramping

**Has your child been diagnosed with an anaphylactic reaction to bees/insect(s)**  Yes  No  
 Reactions to insect  Lungs – breathing wheeze, cough  Mouth – tongue or lips swelling  Skin – hives, rash, local swelling  
 Heart – pale, faint, weak pulse, dizzy  Gut – vomiting, diarrhea, cramping

**Medication Allergy** List medication(s) \_\_\_\_\_  
 Reactions  Lungs – breathing wheeze, cough  Mouth – tongue or lips swelling  Skin – hives, rash, local swelling  
 Heart – pale, faint, weak pulse, dizzy  Gut – vomiting, diarrhea, cramping

**ASTHMA** (Asthma Action Plan may be required)

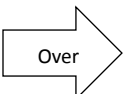
**Is your child currently under medical care for asthma?**  Yes  No Physician Name/Phone \_\_\_\_\_  
 Currently prescribed treatments  Inhaler  Nebulizer  Peak Flow Monitoring  Pump  Oral Antihistamines  
 Triggers  Exercise  Environmental  Other \_\_\_\_\_  
 Date of last hospitalization related to asthma \_\_\_\_\_

**DIABETES**  TYPE I  TYPE II (Diabetic Care Plan may be required)

**Is your child currently under medical care for diabetes?**  Yes  No Physician Name/Phone \_\_\_\_\_  
 Currently prescribed treatments  Insulin  Syringe  Pen  Pump  Glucagon  Blood Testing  
 Oral Medication(s) List \_\_\_\_\_

**SEIZURE DISORDER** (Seizure Action Plan may be required)

**Is your child currently under medical care for seizures?**  Yes  No Physician Name/Phone \_\_\_\_\_  
 Type of seizure  Absence (staring, unresponsive)  Complex partial  Generalized tonic-clonic (grand mal, convulsive)  
 Other (explain) \_\_\_\_\_  
 Date of last seizure \_\_\_\_\_ Length of seizure \_\_\_\_\_  
 Medication(s) List \_\_\_\_\_ Needed at school  Yes  No  
 \_\_\_\_\_ Needed at school  Yes  No



**OTHER CONDITIONS**

Is your child currently under medical care?  Yes  No

Physician Name/Phone \_\_\_\_\_

- Cancer  Heart (circulatory)  Lung  Blood  Kidney (urinary)  Physical Disability  Cerebral Palsy  ADD/ADHD
- Fainting  Headaches

Explain (be specific) \_\_\_\_\_

Medication(s) needed at school?  Yes  No Explain/List \_\_\_\_\_

Special procedures (i.e. catheter, cardiac monitor, etc.) \_\_\_\_\_

**VISION CONDITIONS**

Is your child currently under medical care for a vision condition?  Yes  No

Contacts  Glasses  Other (explain) \_\_\_\_\_

**HEARING CONDITIONS**

Is your child currently under medical care for a hearing condition?  Yes  No

Hearing Aids  Cochlear Implants  Other (explain) \_\_\_\_\_

**ADDITIONAL INFORMATION**

Please list any additional information you feel may be helpful while your child is at school.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART III**

**INSURANCE INFORMATION**

Is your child covered by a Health Insurance Program?  Yes  No

Would you like information sent home about a State Health Insurance Plan?  Yes  No

**PART IV – PLEASE READ CAREFULLY, COMPLETE, AND SIGN**

**EMERGENCY AUTHORIZATION AND SHARING OF INFORMATION**

In case of an emergency, and I cannot immediately be reached, I authorize officials of Greene County Public Schools to contact any persons previously named by me. It is **MY** responsibility to ensure the school has all necessary emergency contact information.

I  **DO**  **DO NOT** authorize officials of Greene County Public Schools to discuss condition(s), treatment(s), concerns, etc. with the physician(s) listed and the Health Department as necessary for the health of my child.

In the event physicians, parent/guardian, or other persons named by me cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of my child. I will not hold the school district financially responsible for the emergency care and/or transportation for my child.

I  **DO**  **DO NOT** authorize the school nurse to share this health information with my child’s teachers, bus drivers, and other appropriate school staff that may be responsible for the care of my child during the school day.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**PLEASE RETURN COMPLETED FORM TO SCHOOL TOMORROW**

**PARENT/GUARDIAN IS RESPONSIBLE FOR PROVIDING THE SCHOOL WITH ANY MEDICATION, SPECIAL FOOD, OR EQUIPMENT THAT THE STUDENT WILL REQUIRE DURING THE SCHOOL DAY. CONTACT THE SCHOOL NURSE TO OBTAIN MEDICATION AUTHORIZATION FORMS AND OTHER PROCEDURE FORMS LISTED, OR ACCESS THEM THROUGH OUR WEBSITE.**