Greene County Public Schools

Every Child · Every Chance · Every Day

Student Health Information

To be completed by Parent/Guardian each school year

PART I

Student Name	Last	First	Middle	☐ Male ☐ 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) _____

ADITIONAL 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.