GLOUCESTER COUNTY PUBLIC SCHOOL

Student Health History Form

School Year 2020__ - 2021_

Teacher:_____

_____/_____/_____ **DOB:** ___/___/____ **Grade:**_____

STUDENT Name: Last First Middle Initial

Does your child have 504? Yes / No IEP? Yes / No

1. Check if your child has history of OR is currently experiencing any of the following; explain (?) answers in #2 below:

	? Allergy to food(s)		? Concussion/head injury (Mo/Year)		Juvenile Rheumatoid Arthritis
	?Allergy to medication(s)		Cystic Fibrosis		Migraines (diagnosed by MD)
	? Environment/stinging insect allergy		Dental Problems / Braces		? Muscle/Back injury
	ADD/ADHD (circle)		Diabetes		? Chronic Pain
	Anxiety / Depression (circle)		? Eating Disorder (what type)		Scoliosis
	? Asthma that is treated with inhaler		Eczema/Chronic Skin Condition		Seizure Disorder/Epilepsy/Tics
	Autism Spectrum		? Emotional/Mental Health (what)		Sickle Cell Disease
	? Bladder/Kidney disease		? Endocrine Disorder (what)		? Sleep problems
	? Bleeding/Clotting Disorder		? Fainting/Blacking out (frequency)		Smoker
	Broken bones/Dislocations		Frequent Headaches		? Stomach/Bowel problems
	? Cancer (type/location if applicable)		Hearing/Speech/Vision Problems (circle)		? Surgery (type)
	Celiac Disease		? Heart Condition		? Weight concerns
	Cerebral Palsy		High/Low Blood Pressure		? Other Illness/Injury
	Chronic diarrhea/constipation (circle)		? Impaired Mobility/ Device (what)		

***NOTE:** An Emergency Action Plan is required for a student who has **Diabetes**, **Asthma** treated with inhaler (including exercise-induced asthma), **Seizures** and/or **Life-threatening Allergies** that require an Epi-Pen. Forms are available in the school clinic, online on the Health and Safety page of the GCPS website, or from your child's health care provider.

2. Briefly explain (?) checked answers here (include month and year for history of a problem):

_____

_____

3. Is your child currently undergoing medical care or psychological treatment? Briefly explain here_____

_____

_____

4. ASTHMA and/or ALLERGIES **(food, medicine, environmental, seasonal),** FILL in the BACK of this form.

5. MEDICATION taken at home (daily or as needed basis), to treat the above noted health issues:

_____

_____

6. **Does your child have a health condition that restrict participation in Physical Education? If yes,** provide a note from your child's health care provider stating the health condition and what restrictions are required, and effective to date(s).
7. Does your child have a DENTIST? YES / NO
   Provider Name:_____ Phone: _____
8. Does your child have a HEALTH CARE Doctor? YES / NO
   Provider Name: _____ Phone:_____
9. HEALTH INSURANCE (Check One): ☐FAMIS MEDICAID ☐PRIVATE ☐TRICARE ☐ NONE

Continued on back

CHECK THE APPROPRIATE BLANKS FOR ALL THREE CONDITIONS: Please send documentation from your child's physician if a previously reported health condition no longer requires medication at school.

ASTHMA

____ My child **does NOT** have asthma and **does NOT** use an inhaler.

____ My child **DOES** have asthma. I will bring in the medication and the completed Asthma Action Plan to school. It must be in the school clinic no later than the last Friday of September.

_____ My child **DOES** have asthma but **will not have an Asthma Action Plan or inhaler at school.** I understand that if my child has a severe asthma attack while at school/school functions, that NO medicine is available at the school and 911 will be called. I take full responsibility for the outcome.

ALLERGIES

____ My child **does NOT** have a food, environmental or insect/bee sting allergy that requires an EpiPen.

____ My child **DOES** need medication available at school, and I will bring an Allergy Action Plan and Epipen (AND Benadryl if ordered by the healthcare provider) to the school clinic no later than the last Friday in September.

____ My child **DOES** have a food, environmental or insect/bee sting life threatening allergy but **will not have an Allergy Action Plan or EpiPen at school.** I understand that if my child has a severe allergic reaction at school or a school function that NO medicine is available at school, and 911 will be called. I take full responsibility for the outcome.

My child's reaction to _____
is:_____

_____

SEIZURES

____ My child **does NOT** have a seizure disorder.

____ My child **DOES have a seizure disorder**, and I will bring a Seizure Action Plan and medication (if ordered by doctor) to the school clinic no later than the last Friday in September.

____ My child DOES have a seizure disorder but **will not have a Seizure Action Plan or medication at school.** I understand that if my child has a seizure at school/school functions, that NO medication is available and 911 will be called. I take full responsibility for the outcome.

PARENT/GUARDIAN SIGNATURE

I understand that per GCPS policy, medications/inhalers are not to be at school or carried by the student without proper paperwork being filed in the school clinic; this includes all over-the-counter and prescription medicines and inhalers.

Consent to Share Information: The school nurse has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and healthcare providers for use in meeting the educational and health needs of my student while in school. I agree to notify the school nurse of any changes in medication (to include dosage/frequency), and change in the health status of my child to include new medical diagnosis by a doctor and injuries acquired (concussion, etc.), or if any of the above information changes.

Parent/Guardian PRINTED Name Signature:_____/_____

Date Signed:_____ **Daytime Phone/Contact Number:**_____