STUDENT HEALTH INFORMATION SHEET

HALL COUNTY SCHOOL SYSTEM

Teacher/Grade_____

School Year_____

School Name: _____ **Date of Birth:** _____ **Student Name:** _____

Home address: _____ Home phone: _____

Parent/Guardian: _____ Work #: _____ Shift: _____

Home #: _____ Cell #: _____

Parent/Guardian: _____ Work #: _____ Shift: _____

Home #: _____ Cell #: _____

Special Custody Concerns: _____ (make sure office has court papers)

Two emergency contacts available to pick up your child from school (In case parent/guardian cannot be reached)

Name: _____ Relationship: _____ Phone(s): _____

Name: _____ Relationship: _____ Phone(s): _____

MEDICAL DATA:

Primary Care Provider: _____ Phone #: _____

Medical Insurance Company: _____ **OR** (check one) ☐ Peach Care ☐ Medicaid ☐ None

List **ALL** medications taken at home and school: _____

PLEASE NOTE: A **Medication Permission Form** is required for **medications to be given at school** (with the exception below). For safety reasons, **ALL** medicine furnished to the school must be in an **unopened, original container** brought in by the **parent/guardian**.
For safety reasons, students are not allowed to transport medication to school.

In the **VERY** rare circumstance, Tylenol (Acetaminophen) may enable my child to return to class **based on assessment and clinical judgment of the school nurse**; **I give permission for my child to receive Tylenol from the licensed nurse at school. If a child requires this medication, more than 2 times, the *parent must furnish Tylenol with a Parent Medication Form.***

PARENT/GUARDIAN INITIAL HERE to indicate your consent: _____

1. Acetaminophen _____dose_____route_____date_____time_____**Nurse Signature**
2. Acetaminophen _____dose_____route_____date_____time_____**Nurse Signature**

MEDICAL HISTORY: Check Y or N; if Y, please provide additional info in space provided

☐ Y ☐ N **Asthma**: Inhaler prescribed? ☐ Y ☐ N; Is inhaler needed at school: _____

☐ Y ☐ N **Diabetes**: Type 1 ☐ Type 2 ☐ Comments: _____

☐ Y ☐ N **Seizures**: Currently on medication? ☐ Y ☐ N; Type and Date of last seizure: _____

☐ Y ☐ N **Allergies**: to what? (Food, medications, seasonal) _____

History of **Anaphylaxis** (*life threatening allergies*) to: _____ ☐ Benadryl ☐ Epi- Pen ☐ Other _____

☐ Y ☐ N **Heart disease**; Comments: _____

☐ Y ☐ N **Previous hospitalizations**: _____ **Past Surgeries**: _____

☐ Y ☐ N **Glasses/contacts** ☐ Y ☐ N **Hearing aids** ☐ Y ☐ N **Migraines** ☐ Y ☐ N **Frequent Nosebleeds**

List OTHER diagnoses, illness, limitations, or disabilities not listed: _____

** In the event a previously *undiagnosed* life threatening allergic reaction occurs, the school has partnered with District 02 Health Services to administer the life-saving medication, Epinephrine. Designated school staff is trained to assess, call 911, and administer Epinephrine. When Epinephrine is administered, the student will be transported to the ER for evaluation and further treatment, if needed.

** In the event of any emergency or accident involving this student and the parent/guardian cannot be reached, I give permission to school authorities to take appropriate emergency action, including 911, for transportation to a hospital. I also give permission to the hospital's emergency room staff to treat the student unless I am present and request otherwise. Fees for transportation and medical services will be the responsibility of the parent/guardian.

_____ _____

Signature of Parent/Guardian Date