Pulaski County Schools
Health Information Form

School Year: 2016-2017 Grade: _____ School: _____ Teacher: _____ Sex: M F

Dear Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. Please complete this form and return it to the school nurse as soon as possible. All medical information is kept confidential. It is only shared with Pulaski County School Staff who are responsible for your child's care at school. **Your child will not be allowed to participate in field trips, sports or other extracurricular activities until the school nurse has this signed and completed form on file in the school clinic.**

Student's Last Name: _____ First: _____ Middle Initial: ____ Birth date: _____

Parent/Guardian _____ Phone: Home: _____ Work: _____ Cell #: _____
Emergency Contact(s) _____ Phone: _____
Doctor Name: _____
***Please list any allergies to: Foods:** _____
Bees/Insects: _____ **Latex:** _____

Are any of these allergies severe enough to require an Epi-Pen? Yes_____ No_____ (If an **Epi-Pen is required**, we must have a written and signed Medication Authorization Form from physician and signed by parent.)

Chronic, Recurring and Special Health Conditions (Please check any of the following that apply)

****Asthma**		Hearing Problems/deafness	
Attention Deficit/Hyperactivity Disorder (ADD/ADHD)		Hypoglycemia (low blood sugar)	
Anemia/Bleeding Problems		Lead Poisoning	
Autism		Kidney Disease/transplant	
Behavioral Problems		Mental Health Concerns	
Bladder/ Problems and/or wetting accidents		Muscle Problems	
Bone or Joint Disorders		****Seizures**	
Bowel problems and/or accidents		Scoliosis	
Cancer		Sickle Cell Disease	
Cerebral Palsy		Skin Problems/Disease	
Cardiac/Heart Problems/Hypertension		Speech Problems	
Cystic Fibrosis		Spina Bifida/Spinal injury	
Dental Problems/Cavities		Stomach/Intestinal Problem	
Depression		Sleep apnea	
Developmental Delays/Problems		Seasonal Allergies	
***Diabetes**		Thyroid Disease	
Dizziness/Fainting Spells		Weight Problems	
Eating Disorders/problems		Vision Problems/blindness	
Emotional Problems		Medication Allergies:	
Frequent headaches/Migraines			
Frequent Nosebleeds		Other Health Problems (please list)	
Head injury/concussions			

* **Please talk with school nurse about completing a Healthcare plan and medication authorization form.**

Please discuss any health problems you have checked (some health problems may require Medication Administration at school and/or a written health care plan. The school nurse will provide you with the needed Medication Authorization Forms and/or care plans) _____

_____

_____

Complete and sign Page 2

Check here if you want to discuss confidential information with the school nurse. ☐ Yes ☐ No

Equipment or aids used by your child: _____Glasses/Contacts _____Wheelchair _____Hearing Aid _____Crutches _____Walker other (please list): _____

Special medical procedures required by your child during the school day (nebulizer, blood sugar monitoring, tube feeding, catheterization, etc.) **These may require a doctor's order- please talk with the school nurse:**

_____

_____

_____

Medications taken by your child may cause side effects, allergic reactions, changes in personality and other problems. Please list all prescription, over-the-counter, and herbal medications your child is taking at **Home** or at **School** (**medications at school require written authorization from parent and doctor**). Forms are available at your child's school.

Medications taken by your	Dosage	Time(s) Taken	Taken at Home	Taken at School

Is your child covered by: ____Private Insurance _____Medicaid _____FAMIS _____Has no insurance

Does your child have Dental Insurance? Yes_____ No _____

FAMIS is a state and federally funded health insurance program designed to cover children who do not qualify for Children's Medicaid and who do not have private health insurance. Medical, hospitalization, prescription, vision and dental services are provided by FAMIS. If you have questions or would like to sign up for FAMIS you can call toll free **1-855-242-8282, or visit www.coverva.org for more information or to apply online. You may also apply at your local Department of Social Services.**

Signature of Parent/Guardian completing Health Information Form:

Parent/Guardian: _____ **Date:** _____

**If your child's health condition should change, please notify the school nurse.

Revised: April 20, 2016