

Bus No: _____ **SCHOOL NURSE HEALTH INFORMATION FORM**

Year _____ Grade _____ Teacher _____

Name: _____ Birthdate: _____ Gender: Male Female
(Last (First) (Middle))

Parent or Legal Guardian: _____ E-mail: _____
Phone: Home: _____ Work: _____ Cell: _____ Pager: _____

Parent or Legal Guardian: _____ E-mail: _____
Phone: Home: _____ Work: _____ Cell: _____ Pager: _____

Home Address: _____ Zip Code: _____

Emergency Contact: (1) Name: _____ Phone: _____
(2) Name: _____ Phone: _____
(3) Name: _____ Phone: _____

** The emergency contact may release my child from school for medical reasons if the parent/guardian cannot be reached. Yes No

Physician: _____ Phone: _____

Health Insurance: Private Medicaid FAMIS None

Do you need assistance obtaining medical insurance? Yes No

** Roanoke County Public Schools is authorized to release or exchange information during the present school year with the following physician or agency: _____

Preferred hospital in the event of an emergency: _____. Do you give the School permission to call the doctor or send the child to the hospital in the event you cannot be located? Yes No

Acute or Chronic Illnesses (Check all that apply.)

- ADD
- ADHD
- Allergies: Food, Environmental, Seasonal (circle one) Describe: _____ Needs Epi-Pen at school? Yes No
- Anemia
- Asthma: Uses an inhaler at school? Yes No
- Cancer: If yes, describe. _____
- Cerebral Palsy
- Chickenpox (in the past)
- Cystic Fibrosis
- Diabetic: Insulin at school? Yes No Glucagon at school? Yes No Pump? Yes No
- Seizures: If yes, describe. _____
- Fractures: If yes, describe. _____
- Headaches or Migraines (circle one): Followed by a physician for this? Yes No
- Hearing difficulty: If yes, explain. _____ Use hearing aid? Yes No
- Heart Disease: If yes, describe. _____
- Hyperthyroidism
- Hypothyroidism
- Menstrual Problems: If yes, describe. _____ Prescription medication? Yes No
- Scoliosis
- Sickle Cell Anemia
- Spina Bifida
- Gastrointestinal Problems: If yes, describe. _____

Wear Glasses? Contacts?

List All Surgeries

Orthopedic Devices

- Wheelchair
- Crutches
- Braces (arms/legs/back)

Other: _____

Medications

Prescription Drugs: Identify drug(s) and **condition requiring its use.** _____

Over-the-Counter Drugs (Nonprescription): Identify drug(s) and reason for use. _____

Drug Allergies: List and describe reaction when taken. _____

When a **school nurse** is available to assess the needs of the student, I give my permission for the following over-the-counter medication to be given (check yes or no). **Over-the-counter medications are for occasional use only. School staff may not administer these medications.**

- | | | |
|--|------------------------------|-----------------------------|
| < Tylenol (Acetaminophen) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| < Advil (Ibuprofen) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| < Antacid (Tums or generic chewable tablets) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| < Benadryl Elixir (Diphenhydramine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| < Antibiotic Ointment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| < Benadryl Ointment (Diphenhydramine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| < Caladryl Cream/Lotion (Calamine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please indicate any other health condition(s) your child has that is/are not covered on this form. _____

Does your child have a 504 Plan? Yes No An IEP? Yes No

Please indicate any special medical considerations needed for your child. _____

I/We understand that this information may be shared with certain school staff as deemed necessary to ensure the safety and health of the student.

(Parent/Guardian Signature)

(Date)