

Bus No: _____

SCHOOL NURSE HEALTH INFORMATION FORM

Year _____ Grade _____ Teacher _____

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

Parent or Legal Guardian: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Pager: _____

Parent or Legal Guardian: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ 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 (circle yes or no). **Over-the-counter medications are for occasional use only. School staff may not administer these medications.**

▶ Tylenol (Acetaminophen)	Yes	No
▶ Advil (Ibuprofen)	Yes	No
▶ Antacid	Yes	No
▶ Robitussin Cough Syrup (Guaifenesin)	Yes	No
▶ Benadryl Elixir (Diphenhydramine)	Yes	No
▶ Antibiotic Ointment	Yes	No
▶ Benadryl Ointment (Diphenhydramine)	Yes	No
▶ Caladryl Cream/Lotion (Calamine)	Yes	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)