



GLOUCESTER COUNTY PUBLIC SCHOOL
Student Health History Form

School Year 20__ - 20__
Teacher: _____

STUDENT Name: Last _____ / First _____ / Middle Initial _____ DOB: ___/___/___ Grade: _____

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:

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

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:** _____