CONFIDENTIAL HEALTH INFORMATION

STUDENT INFORMATION

LAST:	FIRST:	MI:	Date of Birth:	Gender ☐ M ☐ F
Grade:	School:		Primary Doctor Name:	

CURRENT HEALTH CONDITIONS

*Please check the following health conditions which have been **DIAGNOSED** by a doctor (or other health care provider)*

☐ **The student does not have any medical concerns**

☐ *Diabetes***	☐ Severe Head Injury	☐ Skin	☐ Vision
☐ *Active Seizure Disorder***	☐ Migraines/Chronic Headaches	☐ Bladder/Kidney	☐ Dental
☐ *Severe Allergies***	☐ Heart/Blood	☐ Stomach/Bowels	☐ Hearing
☐ *Asthma***	☐ Muscles/Bones/Joints	☐ Emotional/Behavioral	☐ Other

***REQUIRES** completion of CARE PLAN (obtain from school health office)*

Please describe any of the above conditions you have checked (use other side if necessary): _____

_____

_____

_____

CURRENT MEDICATIONS

*List **ALL** medications including the name of medication, dose, frequency and name of prescriber*

☐ **The student does not require medications at school**

If the student requires over-the-counter or prescription medications or treatments at school (daily or as needed), the health care provider and parent MUST complete and submit the appropriate authorization form(s). Obtain forms from the school health office or NCSD website.

Medications (use other side if necessary): _____

_____

_____

_____

OTHER HEALTH INFORMATION

Prior IEP or 504? If yes, briefly describe: _____

_____

Activity restriction and/or special medical equipment required in school? (e.g. oxygen, wheelchair, catheter):

_____

Have there been any significant changes in your child's health over the last year? If yes, briefly describe: ____

_____

List hospitalizations and/or surgeries and dates (use other side if necessary): _____

_____

***Health Insurance Portability and Accountability Act 1996 (HIPAA) and the Family Education and Right to Privacy Act (FERPA):** I authorize the sharing of my child's health information identified on this Student Health Information Form (SSS-H-16) to provide appropriate school health services. I understand I am responsible for providing the school with any medication(s), special food, and/or equipment that is required during the school day and further agree to complete all requested health care plans. This authorization is effective immediately and until revoked in writing by parent/guardian.*

PARENT/GUARDIAN NAME (PLEASE PRINT): _____

PARENT/GUARDIAN SIGNATURE:_____ **DATE:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Emergency Contact Name: _____**Contact Phone(s):** _____

ADMINISTRATIVE USE			Date/Comments:
504 PLAN OFFERED	YES	NO	

REVISED 04/17/15 SSS-H-16