

# STUDENT HEALTH INFORMATION 2016/2017

(Parent/Guardian to complete both sides)

Child's Name	Grade	Homeroom Teacher	Date of Birth
Mother's Name	Home Phone Number	Work Phone Number	Cell Phone Number
Father's Name	Home Phone Number	Work Phone Number	Cell Phone Number
Emergency Contact	Home Phone Number	Work Phone Number	Cell Phone Number
Physician	Office Phone Number		
Dentist	Office Phone Number		
Specialist	Office Phone Number		
Has your child seen the doctor for a well check within the past 12 months?		YES	NO
Does your child have health insurance?		YES	NO
Does your child have Medicaid/Health Choice?		YES	NO
Has your child ever attended a North Carolina public school?		YES	NO

I give my permission to the school nurse and/or teacher/and or School Based Clinic at the Ashe County Middle School to share or receive health-related information needed to care for my child with the healthcare providers listed above during the 2016/2017 school year.

YES     NO    \_\_\_\_\_ Parent Initials

### AN IMPORTANT MESSAGE ABOUT YOUR CHILD'S HEALTH

The nurse works to promote good health among students and staff. Our goal is to help your child have a healthy, successful school year. The school nurse has guidelines to follow for the care of students on campus. Medications will be given according to the doctor's written direction with parent permission. The nurse does not have a supply of over-the-counter medications such as Tylenol, ointments, etc., to give to students. Students with life threatening allergies to bee stings, foods, or latex will need his/her doctor to provide a written authorization for the injectable medicine (Epi-Pen) to be stored at school. However, should a student have a sudden, undiagnosed, serious life-threatening reaction (anaphylaxis), 911 and the parent/guardian will be called. Trained personnel will administer an initial injectable dose (Epi-Pen). **If your child has a health condition please contact the school nurse to set up a plan of care to meet your child's needs during the school day.**

I/We do further authorize any physician or hospital to render medical care and treatment that may be needed to care for my child without our specific permission or authorization. Parent and/or Guardian: If there are any specific considerations that should be taken into account before rendering medical care or treatment, please complete a statement of explanation.

**Make certain that you notify us of all phone number changes including your child's emergency contact person. Please contact the school nurse if you have any questions.**

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

**NOTICE**

Health screening information will be documented in the health module of PowerSchool. PowerSchool will also be used to notify school staff of medical alerts.

**PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM BEFORE RETURNING**

