ROCKBRIDGE COUNTY
Public Schools

Revised May 2014

Student Health History Form

Legal Last Name:	Legal First Name:	Legal Middle Name:	Preferred Name:
Student Grade Level	**Homeroom Teacher Name**		**Student Age:**

In the event of an emergency, if the school cannot contact you, the school will use the emergency contact information from the student Information Form. This may require that we share *pertinent* information related to the emergency with this contact. Please consider this possibility when you designate your emergency contacts for your child and indicate that they can have necessary information about the emergency that involves why they are picking your child up at school.

Medical Information

Physical Conditions of Concerns (Please check conditions for which your child has been treated or is currently experiencing)*:

☐ Allergy	☐ Cerebral Palsy	☐ Heart Condition/Murmur	☐ Mononucleosis
☐ ADD/ADHD	☐ Chickenpox	☐ Hepatitis	☐ Mumps
☐ Anemia (Include Sickle Cell)	☐ Convulsions/Seizures	☐ Hernia	☐ Bone Disorder
☐ Arthritis	☐ Cystic Fibrosis	☐ Hives	☐ Psychological/Psychiatric
☐ Asthma (Requiring treatment)*	☐ Diabetes	☐ Hypertension	☐ Scoliosis
☐ Back/Neck Injury	☐ Food Allergies	☐ Lead Exposure	☐ Skin Disorders
☐ Bladder/Kidney Disease	☐ Head Injury/Concussion	☐ Lung Disease/Tuberculosis	☐ Speech Disorder
☐ Bleeding/Clotting Disorder	☐ Headaches	☐ Measles	☐ Spina Bifida
☐ Cancer/Leukemia	☐ Hearing Loss	☐ Medication Allergies	☐ Vision Loss/Correction

***Please, check only if your child has required medication and/or treatment for asthma within the past 2 years – checking this will require an action plan to be written and implemented**

Please Specify Allergies and reactions if noted above:

Over-The-Counter Medication

Rockbridge County Schools' policy states that we can only administer over the counter medication brought in by the parent. ***Medication must be in its original sealed bottle***. We will only administer Tylenol for complaints 2 times a week without documentation from your child's physician because of the potential for side effects with unsupervised, long- term use.

I give my permission for my child to have the following medication if a nurse or school personnel feel it is necessary:

- Tylenol	☐ Yes	☐ No	I want to be notified in writing if administered	☐ Yes	☐ No
- Cough drops	☐ Yes	☐ No	I want to be notified in writing if administered	☐ Yes	☐ No
- Benadryl	☐ Yes	☐ No	(Benadryl is used for emergencies only & you will be notified)		
- Advil	☐ Yes	☐ No	I want to be notified in writing if administered	☐ Yes	☐ No
- Antacid (TUMS)	☐ Yes	☐ No	I want to be notified in writing if administered	☐ Yes	☐ No
- Antibiotic Ointment	☐ Yes	☐ No	I want to be notified in writing if administered	☐ Yes	☐ No
- Anit-itch cream/spray	☐ Yes	☐ No	I want to be notified in writing if administered	☐ Yes	☐ No
-					

Other Health Needs and Notes (Also note any religious beliefs which may impact this student's medical care):

Is your child taking medication (Prescription or over-the-counter) on a regular basis? _____ yes _____ no Please specify:

Medication: _____ Dosage: _____

Reason for use: _____

Medication: _____ Dosage: _____

Reason for use: _____

Physician:	Physician Phone:	Dentist:	Dentist Phone:
Preferred Hospital:	**Insurance** ☐ Medicaid ☐ FAMIS ☐ Private: _____		**Policy Number (Optional):**

Permissions & Authorizations

Medical Authorizations (Sign One)

*A school nurse may require additional information about certain medical conditions

CONSENT FOR TREATMENT

In the event that reasonable attempts to contact me have been unsuccessful, I HEREBY GIVE MY CONSENT for:
1) the administration of any treatment deemed necessary by the physician/dentist above or in the event the designated preferred practitioner is not available, by another licensed practitioner; and
2) the transfer of my child to the hospital above or to any hospital reasonably accessible. I accept full financial responsibility for the payments of all charges made for medical services rendered. I absolve school officials of any liability who in good faith complies with this request.

√ Parent/Guardian Signature:_____
Date: ___ / ___ / ___

REFUSAL OF CONSENT

I ***DO NOT give my consent for emergency medical treatment*** of my child. In the event of illness or injury requiring immediate treatment to a life-threatening situation, I acknowledge that the school will do what is necessary until I can arrive at my child's school/location.

√ Parent/Guardian Signature:_____
Date: ___ / ___ / ___

Medical Authorization Cont

I **DO** acknowledge that it is necessary for the school nursing staff to notify school administrators of any medical condition relating to: allergies, asthma, seizures, and diabetes or any other condition that would require attention/ or awareness during the school day or at school activities.

√ Parent/Guardian Signature:

_____Date: ___ / ___ / ___

I understand and accept that Rockbridge County Schools, its employees, agents or designees are not responsible for any effect of the medication I have approved to be administered above.

√ Parent/Guardian Signature:

_____Date: ___ / ___ / ___

Parent / Guardian Signature

I CERTIFY that, to the best of my knowledge, the information provided in this document is accurate as of the date shown below. I understand that I have the right to see any documentation kept by Rockbridge County Schools in relation to my child. I understand that data pertaining to my child's health needs will only be released to other educational authorities after filing a Release of Transcripts application with the appropriate school. I do understand that in the case of an emergency that pertinent health information will be shared with the medical authorities treating your child. I understand that it is my responsibility to notify my child's school should any of the information listed on this form change.

√ Parent/Guardian Signature:

_____

Date: ___ / ___ / ___

Parent/Guardian Signature:

_____

Date: ___ / ___ / ___