

**Montgomery County Public Schools
Health Information Form
2011-2012**

Dear Parent/Guardian: This form is needed to complete your student's registration. This information helps us meet the health care needs of your child. It may also help us determine the need for additional health services in our schools. **All medical information is kept confidential. See privacy statement below.** If your child's health condition should change, please notify the school nurse. Thank you for your assistance.

PLEASE FILL OUT BOTH SIDES OF THIS FORM

STUDENT NAME:		SCHOOL:		GRADE:
BIRTH DATE: / /		AGE:	HOME ROOM TEACHER:	
ADDRESS:				
PARENT/GUARDIAN:		HOME PHONE #:	WORK PHONE #:	CELL PHONE #:
EMERGENCY CONTACT:		RELATIONSHIP:	PHONE #:	CELL PHONE #:
PRIMARY DOCTOR:		MD LOCATION:		PHONE #:
OTHER MD/ SPECIALIST:		MD LOCATION:		PHONE #:

If I cannot be reached in an emergency, I give permission for my child to be treated by the following doctor or hospital:

Doctor: _____

Hospital: _____

I give the school nurse permission to contact my child's doctor to discuss medications that he/she takes at school, care plans, information on this form, immunizations, and/or urgent situations. The school nurse will then follow up with me.

YES **NO** **I HAVE QUESTIONS REGARDING THIS** (Please contact the school nurse with these questions.)

INSURANCE COVERAGE: Is your child covered by any of the following?

Private insurance (Name of carrier) _____ Medicaid FAMIS

School insurance No insurance Other _____

I would like to receive information on how to obtain health insurance by: (Circle one) mail or a FAMIS representative.

DENTAL: Has your child been seen by a dentist in the last 12 months? YES NO

Medications taken by your child may cause side effects, allergic reactions, changes in personality, and other problems.

Please list all medications your child is taking at home and/ or at school.

Medication	Dosage	Time(s) Taken	Taken at Home	Taken at School

If your child needs medication at school or during an after school activity you will need to supply the medication and complete a written permission form signed by the parent and/or doctor. Forms may be obtained from the school.

*This section **MUST** be completed:*

-Will your child be taking part in after-school (school-sponsored) activities or overnight school trips? Yes / No

If yes, please list any activities that you know your child will be taking part in: _____

-Will your child need a medical procedure or medications during after-school (school- sponsored) activities or overnight school trips? Yes / No

If yes, please list the medication and/or procedure and times it is to take place or be administered: _____

*****Please be advised that you are responsible for notifying the school nurse and the after- school activity teacher and/or coach of changes in your child's medical condition. *****

PLEASE FILL OUT REVERSE SIDE

Equipment or aids used by your child: ___Glasses/Contacts ___Wheelchair ___Hearing Aid ___Cane ___Crutches ___Walker ___Oxygen
 ___Ventilator ___Cochlear Implant ___Other (please specify): _____

Special medical procedures required by your child during the school day (nebulizer, blood sugar monitoring, tube feeding, catheterization, etc).
(These procedures will require a doctor's order- please talk with the school nurse)

***ALLERGIES:** List Food, Medicine, Insects, Latex, or Other allergies: _____
Does this allergy require use of an emergency medication "Epi-Pen" device? YES NO
-SEASONAL ALLERGIES: ___YES ___NO
-LIST ALL FOOD EXCLUSIONS DUE TO CULTURAL OR RELIGIOUS REASONS: _____

Current, DIAGNOSED BY MD, Health Problems and Treatment (Please check any of the following):

* Asthma-diagnosed & takes medication	Emotional Problems / Mental Health Concerns
Uses inhaler ___YES ___NO	Eye Disease/Problems (Not glasses)
Uses Nebulizer at school ___Yes ___NO	Gastric Reflux/ Heartburn (Frequently)
*Diabetes: ___Type 1 ___Type 2	Headaches/ Migraines- Frequently
Monitors Blood Glucose at school ___YES ___NO	Hearing Impairment
Uses Insulin Pump ___YES ___NO	Heart (Cardiac) Problems
Uses Insulin via syringe ___YES ___NO	High Blood Pressure
*Seizures	Hypoglycemia
Uses Diastat ___YES ___NO	Irritable Bowel Syndrome (IBS)
Anemia	Kidney Disorders
Anxiety- Excessive	Liver Disease
Arthritis- Juvenile Rheumatoid	Muscle Disease/ Disorder
Attention Deficit/ Hyperactivity Disorder	Nausea/ Vomiting (Frequently)
Autism Spectrum Disorder	Neck Injury
Bipolar Disorder	Nerve Disease/ Disorder
Bladder Problems/Wetting Problems	Neurofibromatosis
Bone or Joint Disorders	Polycystic Ovarian Syndrome (PCOS)
Bowel Accidents or Problems	Scoliosis
Brain/Head Injury- Traumatic	Sickle Cell Disease
Cancer, Tumors, and/or Growths	Sinus Problems
Celiac Disease	Skin Disease or Problems
Cerebral Palsy	Speech Impairment
Cystic Fibrosis	Spina Bifida
Dental Problems (NOT Braces)	Spinal Injury
Depression	Stomach Disorders
Developmental Delays/ Difficulties	Thyroid Condition
Dizziness/ Fainting Spells	Throat Problems
Down Syndrome	Tuberculosis Exposure
Ear Disease/Problems	Ulcer
Eating Disorders/ Feeding Problems/ Tube Feeding	Other (specify): _____

***These items will require a plan of care to be developed in order to provide your child with more specialized care.**

___ Yes, I would like a medical plan of care. I understand that I and my child's doctor will complete and sign this plan of care.
 ___ No, I decline a medical plan of care for my child who has allergies, asthma, diabetes, and/or seizures.

Please tell us more about the health problems you have checked: _____

Deemed Consent/ Privacy Statement:

As a health care provider, we are required by Section 32.1-45.1 of the Code of Virginia (1950), as amended to give you the following notice:

1. If one of our health care professionals, workers, or employees should be directly exposed to your child's blood or body fluids in a way that may transmit a disease, you will be asked to have your child's blood tested for infection with human immunodeficiency virus (the "AIDS" virus). A physician or other health care provider will tell you and the exposed person the result of the test.

If your child should be directly exposed to the blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus). A physician or other health care provider will tell you and that person the result of the test.

By signing this form, I authorize the release of my child's medical information by the school system to authorized school personnel to benefit the health, safety, and educational progress of my child and to the physician(s) named on this form, the EMS, and/or the hospital provider involved in the emergency care of my child. I have read the Deemed Consent for HIV and/or Hepatitis B or C exposure on this form and I understand it.

Parent/Guardian Signature: _____ **Date:** _____

***If you have any questions regarding this form or comments about the information you put on this form, please contact your child's school nurse. ***