Montgomery County Public Schools
Health Information Form
2009 – 2010

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:	TEACHER:		
ADDRESS:				
PARENT/GUARDIAN:		HOME PHONE #:	WORK PHONE #:	CELL PHONE #:
EMERGENCY CONTACT:		RELATIONSHIP:		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, and/or urgent situations. The school nurse will then follow up with me.

_____YES ______NO _______I HAVE QUESTIONS REGARDING THIS.

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

___ Private insurance (Name of carrier)_____________________ _____Medicaid _____FAMIS

____School insurance ___Other___________________________

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

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.
2. 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.

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.

If your child needs medication at school, 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.

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

Equipment or aids used by your child: ___Glasses/Contacts __Wheelchair __Hearing Aid ___Cane ___Crutches ___Walker ___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)**____
____

PLEASE FILL OUT REVERSE SIDE

ALLERGIES to *Food, Medicine, Insects, or Other Items: ***Does this allergy require use of an emergency medication "Epi-Pen" device?   YES   NO***
SEASONAL ALLERGIES:

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

	* Asthma-diagnosed & takes medication		Head Injury
	Uses inhaler		Hearing Impairment
	*Diabetes		Heart Problems
	*Seizures		High Blood Pressure
	Anxiety- Excessive		Kidney Disease
	Arthritis		Liver Disease
	Attention Deficit/ Hyperactivity Disorder		Mental Health Concerns
	Autism		Muscle Disease/ Disorder
	Behavioral Problems		Nausea/ Vomiting (Frequently)
	Bladder Problems		Neck Injury
	Bone or Joint Disorders		Nerve Disease/ Disorder
	Bowel Accidents or Problems		Neurofibromatosis
	Cancer, Tumors, and/or Growths		Other Breathing Problems
	Cerebral Palsy		Sickle Cell Disease
	Cystic Fibrosis		Sinus Problems or Headaches
	Dental Problems (NOT Braces)		Skin Disease or Problems
	Depression		Speech Impairment
	Developmental Delays/ Difficulties		Spinal Bifida
	Dizziness/ Fainting Spells		Spinal Injury
	Ear Disease		Stomach Disorders
	Eating Disorders/ Feeding Problems		Throat Problems
	Emotional Problems		Tuberculosis Exposure
	Eye Disease		Ulcer
	Gastric Reflux/ Heartburn (Frequently)		Wetting Problems
	Headaches/ Migraines- Frequently		Other (specify):

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

____ I would like a medical plan of care for my child who has allergies, asthma, diabetes, and/or seizures. I understand that I and my child's Medical Doctor will complete and sign this medical plan of care.

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

*****Will your child be taking part in after-school (school-sponsored) activities or overnight school trips?   Yes / No***
If yes, please list the activities 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 medical procedure and times the procedure or medication is to take place or be administered:
____

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

****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. ****

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 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:** ___________________

*** This area **MUST** be completed.*