

**Montgomery County Public Schools  
Health Information Form  
2020-21**

**All medical information is confidential. See privacy statement below.** If your child's health condition changes, please notify the school nurse.

**\*\*\*IF COMPLETING A PAPER FORM, PLEASE USE BLACK or BLUE INK ONLY\*\*\***

STUDENT NAME:	BIRTH DATE:	SCHOOL:	GRADE/HOMEROOM:
PARENT/GUARDIAN CONTACT :	HOME PHONE #:	WORK PHONE #:	CELL PHONE #:
EMERGENCY CONTACT #1:	RELATIONSHIP:	PHONE #:	ALT PHONE #:
EMERGENCY CONTACT #2:	RELATIONSHIP:	PHONE #:	ALT PHONE #:

Does your child have a family physician?  Yes (Name/# of provider) \_\_\_\_\_  No  
 Does your child have a regular dentist?  Yes (Name/# of dentist) \_\_\_\_\_  No

**\*\*\*If I cannot be reached in an emergency, I understand my child will be transported to the nearest hospital via EMS.**

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

Private (Name of carrier) \_\_\_\_\_  Medicaid  FAMIS  School insurance  
 None: Would you like to receive information on how to obtain health insurance?  **YES**  **NO**

**EQUIPMENT OR AIDS USED BY YOUR CHILD:**  Oxygen  Ventilator  Wheelchair  Other \_\_\_\_\_

**SPECIAL MEDICAL PROCEDURES** required by your child (**will require a physician order--please speak with the school nurse**):

Nebulizer  Blood sugar monitoring  Tube feeding  Catheter  Other \_\_\_\_\_

**ALLERGIES:**

FOOD \_\_\_\_\_  
 INSECTS \_\_\_\_\_  
 MEDICINE \_\_\_\_\_  
 LATEX \_\_\_\_\_  
 OTHER \_\_\_\_\_

**\*\*\*Does any allergy require use of an emergency EPIPEN?  YES (requires an emergency action plan)  NO**

**CURRENT DIAGNOSED HEALTH PROBLEMS AND TREATMENT (Please check all that apply):**

<b>**Asthma-HAS TAKEN MEDICATION WITHIN PAST 2 YEARS</b>	Attention Deficit/Hyperactivity Disorder
~Does student use an inhaler? YES NO	Autism Spectrum Disorder
~Does student use a nebulizer? YES NO	Brain Injury/Concussions
<b>**Diabetes:</b> <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	Celiac Disease
~Blood glucose monitoring via: CGM AccuChek	Developmental Delays/Difficulties
~Does student use an insulin pump? YES NO	Emotional/Mental Health Concerns
~Does student take insulin via syringe? YES NO	Eye Disease/Problems (not glasses)
<b>**Seizures-HAS HAD A SEIZURE WITHIN PAST 2 YEARS</b>	Hearing Impairment
~Type of seizures: _____	Neck/Spinal Injury
~What are seizures triggered by? _____	Other (specify):
~Does student have Diastat ordered? YES NO	

**\*\*\*Unless declined in writing, Asthma, Allergies requiring EPIPEN, Diabetes and Seizures require an action plan signed by both physician and parent/guardian in order to provide your child with more specialized care.**

**\_\_\_\_\_ I decline a medical plan of care for my child who has asthma, life-threatening allergies, diabetes, and/or seizures. (please initial)**

**If necessary, please tell us more about the health problems you checked:**

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STUDENT NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

Please list any scheduled medication your child is currently taking, and indicate whether it is taken at home and/or at school.

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

I give my permission for the following over-the-counter (OTC) medications to be administered by the school nurse as needed, according to package directions and based on age/weight:

All OTC medications listed below \_\_\_\_\_ YES \_\_\_\_\_ NO

(If no, please check those OTC medications you give permission to be administered by the nurse.)

- Ibuprofen*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Allergy relief medication (cetirizine/Zyrtec)*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Acetaminophen*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Anti-itch spray/cream (hydrocortisone)*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Cough drops*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- TUMS Antacid*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Saline eye drops*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Vaseline*..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Burn/Sting relief spray (lidocaine)* ..... \_\_\_\_\_ YES \_\_\_\_\_ NO
- Antiseptic wash*..... \_\_\_\_\_ YES \_\_\_\_\_ NO

**PLEASE NOTE:** OTC medications are for *occasional* use only. If your child takes OTC medication on a regular basis or needs a dose outside of package label directions, a doctor’s order is **required** in order for school nurses to administer these medications, and the medication must be supplied by the parent/guardian. **School staff, other than the nurse, may not administer these medications from the school’s supply of medications; therefore school-supplied OTC medications will not be sent on field trips.**

If your child needs other medication or medical treatment during school or after-school activities, please notify your school nurse. The parent/guardian will need to supply the medication in its original container and complete an MCPS Medication Permission Form for each medication (available at school or online @ [mcps.org](http://mcps.org) under SCHOOL HEALTH). For after-school activities, please provide the nurse with medication at least **3 days in advance**.

Please be advised that you are responsible for notifying the school nurse AND after-school sponsor of any changes in your child’s medical condition.

**DEEMED CONSENT/PRIVACY STATEMENT:**

As a health care provider, we are required by Section 32.1-45.1 of the Code of Virginia, as amended to give you the following notice:  
 -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 human immunodeficiency virus, Hepatitis B or C viruses. 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, Hepatitis B or C viruses. 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.