EFFINGHAM COUNTY SCHOOL HEALTH SERVICES
ANNUAL STUDENT HEALTH INFORMATION
~ CONFIDENTIAL ~

Name of Student **DOB** **Grade** **Homeroom Teacher**

PART I: Student Health Status

Does your child have ANY of the following health conditions:

Asthma? ☐ **Yes** **Medications taken** _____

Severe allergies? (other than seasonal) ☐ **Yes** **Allergic to:**_____**Epipen Prescribed?**___

Diabetes? ☐ **Yes** **Meds/Dose:**_____

Seizures? ☐ **Yes** **Type of seizure and medication taken:**_____

ADD/ADHD? ☐ **Yes** **Medications taken**_____

If your child has any chronic health condition (such as asthma, diabetes, seizures, severe allergies, etc.) you MUST provide an Action Plan signed by the student's doctor at the start of each school year. Failure to provide these necessary doctor's orders by the end of the second week of school will result in the student being excluded from school.

	Yes	No
Heart Problem/Defect		
Anemia (include sickle cell)		
Arthritis		
Back/Neck Injury or Condition		
Blood/Clotting Disorder		
Cancer/Leukemia		
Diet Restrictions		
Head Injury/Concussion		
Headaches		

	Yes	No
Hearing Deficit (explain correction below)		
Hepatitis		
Surgery		
Activity Restrictions		
Physical Disability		
Mononucleosis		
Vision Deficit (explain correction below)		
Other (explain below & on back)		

Please give details for all that are marked YES above

PART II: ALL Current Medications

Does the student take ANY medication (prescribed and/or over the counter (OTC)? _____

List: Include med dosage, reason and frequency _____

Is medication required during school hours? ☐ **Yes** ☐ **No**

If yes, please obtain necessary permission form at registration or from t **the nurse.**

☐ **Yes** ☐ **No** **CONSENT TO CONTACT DOCTOR: The school nurse has permission to contact my child's doctor if medically necessary.**

- **I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.**
- **I understand that medications of any kind are not allowed on school grounds without the proper medical authorization on file and must be brought to the school by the parent/adult.**
- **I understand that school staff, including the nurse, MAY NOT administer or assist with any medication without the proper medical authorization on file.**
- **I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information be shared, I must request this in writing and file it with the school nurse.**

_____ _____

Parent/Guardian Signature **Telephone #** **Date**