ECCA
EFFINGHAM COLLEGE & CAREER ACADEMY

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

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Circle one: **ECHS** **SEHS**

Name of Student **DOB** **Grade** **ECCA Teacher**

PART I: Student Health Status

Complete the following checklist by indicating any of the following conditions, past or present. Include a separate sheet if additional information is necessary.

Does your child have asthma? ☐ Yes ☐ No **If yes, medications taken** _____
☐ *Mild* ☐ *Moderate* ☐ *Severe*

Does your child have severe allergies? ☐ Yes ☐ No **Type of allergy** _____
(other than hay-fever/seasonal) ☐ *Mild* ☐ *Moderate* ☐ *Life Threatening* ***Epipen Prescribed?*** *Yes* ☐ *No* ☐

Does your child have diabetes? ☐ Yes ☐ No **If yes, describe monitoring meds taken; blood sugar checks below:**
Meds Taken ☐ Yes ☐ No **Describe below or on the back side:** _____
Blood Sugar Checks ☐ Yes ☐ No _____

Does your child have seizures? ☐ Yes ☐ No **If yes, describe type and meds taken**

	Yes	No
Heart Problem/Defect		
ADD/ADHD		
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		
Epilepsy		
Vision Deficit (explain correction below)		
Other (explain below & on back)		

Please give details for all that are marked YES above

PART II: Current Medications

Does the student take ANY medication (prescribed and/or over the counter (OTC)? ☐ Yes ☐ No

Explain: 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 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**