

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

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

**PART I: Student Health Status ~ CHRONIC HEALTH ISSUES**

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.

*Does your child have ANY of the following CHRONIC/SEVERE 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 \_\_\_\_\_

For all other health issues/concerns, please mark below and add explanation on lines provided or on back of form:

	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		
Hepatitis		

	Yes	No
Surgery		
Activity Restrictions		
Physical Disability		
Mononucleosis		
Vision Deficit (explain correction below)		
Hearing 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))? \_\_\_\_\_

Is medication required during school hours?  Yes  No

*If yes, please obtain necessary permission form from the school nurse.*

List: Include med dosage, reason and frequency \_\_\_\_\_

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 \_\_\_\_\_