# STUDENT HEALTH INFORMATION FORM • Alexandria City Public Schools



**Student's Last Name:** _____ **First Name:** _____

**Date of Birth:** _____ **Grade:** _____ **School Year:** _____

## STUDENT HEALTH CONDITIONS

Check all boxes that apply to the student.

### ALLERGIES ☐ Yes ☐ No

**Allergy Type:**

- ❒ Food List food(s): _____
- ❒ Medication List medication(s): _____
- ❒ Bee stings or insect bites
- ❒ Other: _____

**Date of last severe reaction:** _____

**Date of last hospital or emergency room visit due to allergies:** _____

**Currently prescribed medications and treatments for allergies:**

- ❒ Oral antihistamine (Benadryl, etc.)
- ❒ Epinephrine ❒ Has Epi-Pen
- ❒ Other: _____

### FOOD RESTRICTIONS ☐ Yes ☐ No

- ❒ Due to Gastrointestinal (Digestive) distress List food(s): _____
- ❒ Due to religious or other preferences List food(s): _____

### ASTHMA ☐ Yes ☐ No

**Currently prescribed medications and treatments for asthma:**

- ❒ Daily control (prevention) medication
- ❒ As needed (rescue) medication

**Date of last hospital or emergency room visit due to asthma:** _____

### DIABETES ☐ Yes ☐ No

**Date of last hospital or emergency room visit due to diabetes:** _____

**Does the student's diabetes require medication and/or blood testing IN SCHOOL?**

- ❒ No
- ❒ Yes List medication(s): _____

### SEIZURE DISORDER ☐ Yes ☐ No

**Does the student's seizure disorder require medication IN SCHOOL?**

- ❒ No
- ❒ Yes List medication(s): _____

**Date of last seizure:** _____

**Date of last hospital or emergency room visit due to seizure:** _____

## OTHER HEALTH CONDITIONS ☐ Yes ☐ No

- ❒ ADHD
- ❒ Autism
- ❒ Cerebral Palsy
- ❒ Developmental Delay
- ❒ Congenital Heart Defect
- ❒ Hemophilia
- ❒ Sickle Cell Disease
- ❒ Cystic Fibrosis
- ❒ Obstructive Sleep Apnea
- ❒ Nutritional Disorder
- ❒ Physical Disability
- ❒ Eczema
- ❒ Cancer
- ❒ Chronic Infection (Hepatitis C, HIV)
- ❒ Congenital/Chromosomal Disorders
- ❒ Depression

❒ Other physical or mental health conditions: _____

**Does the student's condition require IN SCHOOL USE of the following?**

**Medications:** ❒ No ❒ Yes List medication(s): _____

**Special procedures:** ❒ No ❒ Yes List procedure(s): _____

**Special equipment:** ❒ No ❒ Yes List equipment: _____

## VISION CONDITIONS ☐ Yes ☐ No

- ❒ Glasses
- ❒ Contacts
- ❒ Non correctable
- ❒ Other: _____

## HEARING CONDITIONS ☐ Yes ☐ No

- ❒ Hearing aid(s)
- ❒ Non correctable
- ❒ Other: _____

## STUDENT HEALTH CARE AND HEALTH COVERAGE

**Does the student have health insurance?** ❒ No ❒ Yes Name of health insurance company: _____

Name of student's primary care doctor: _____ Phone: _____

**Does the student have dental insurance?** ❒ No ❒ Yes Name of dental insurance company: _____

Name of student's dentist: _____ Phone: _____

## PARENT/GUARDIAN AUTHORIZATION

**In the case of an emergency, school staff will call 911. Every attempt will be made to contact a parent, legal guardian or emergency contact.**

The parent/guardian is responsible for providing the school with any medication, special food or equipment that the student requires during the school day. Check with the school nurse or registrar to obtain correct medication and procedural forms. If an individual school health care plan is indicated, the parent/guardian is responsible for providing the school nurse with necessary medical information, appropriate authorization forms and written consent to exchange information with the child's physician.

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Parent/Guardian Signature: _____ Date: _____