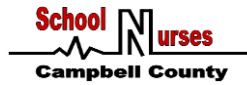




# Campbell County School District #1



## Nursing Services

### CONFIDENTIAL STUDENT HEALTH FORM

<b>LAST:</b>	<b>FIRST:</b>	<b>MI:</b>	Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Grade:	Primary Doctor:	Dentist:		

### CURRENT HEALTH CONDITIONS

Please check the following health conditions which have been **DIAGNOSED by a doctor** (or other health care provider).

The student does not have any health concerns.

- |  |  |  |                                    |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Diabetes**                | <input type="checkbox"/> Stomach/Bowel               | <input type="checkbox"/> Genetic Disorders     | <input type="checkbox"/> Cancer    |
| <input type="checkbox"/> Active Seizure Disorder** | <input type="checkbox"/> Bladder/Kidney              | <input type="checkbox"/> Problems at Birth     | <input type="checkbox"/> Skin      |
| <input type="checkbox"/> Asthma**                  | <input type="checkbox"/> Heart/Blood                 | <input type="checkbox"/> Emotional/Behavioral  | <input type="checkbox"/> Dental    |
| <input type="checkbox"/> Severe Allergies**        | <input type="checkbox"/> Muscles/Bones/Joints        | <input type="checkbox"/> ADD/ADHD              | <input type="checkbox"/> Hearing   |
| <input type="checkbox"/> Allergies (not severe)    | <input type="checkbox"/> Head Injury/Concussion      | <input type="checkbox"/> Glasses/Contacts      | <input type="checkbox"/> Ear Tubes |
| <input type="checkbox"/> Special Dietary Needs     | <input type="checkbox"/> Migraines/Chronic Headaches | <input type="checkbox"/> Other Vision Concerns | <input type="checkbox"/> Other     |

\*\*Please consult with school nurse regarding Individual Health Plan for this diagnosis.

Please describe any of the above conditions you have checked (use other side if necessary): \_\_\_\_\_

### CURRENT MEDICATIONS

List ALL medications including the name of medication, dose, and schedule.

The student does not take any medications.

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

If the student requires medications or treatments at school (daily or as needed), the health care provider and parent MUST complete and submit the appropriate authorization form(s). Obtain form(s) from the school or CCSD website.

### OTHER HEALTH INFORMATION

Prior or current IEP or 504? If yes, briefly describe: \_\_\_\_\_

Activity restriction and/or special medical equipment required in school? (e.g. oxygen, wheelchair, catheter): \_\_\_\_\_

### INJURIES, SURGERIES, HOSPITALIZATIONS

Injuries	Date	Surgeries	Date	Hospitalizations	Date

Health Insurance Portability and Accountability Act 1996 (HIPAA) and the Family Education and Right to Privacy Act (FERPA): I authorize the sharing of my child's health information identified on this form to provide appropriate school services. I understand I am responsible for providing the school with any medication(s), treatment supplies, and/or equipment that is required during the school day and further agree to complete all requested health care plans and notify school nurse of health updates or medications changes. This authorization is effective immediately and until revoked in writing by parent/guardian.

PARENT/GUARDIAN NAME (PLEASE PRINT): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**CURRENT HEALTH CONDITIONS CONTINUED (IF NECESSARY)**

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**CURRENT MEDICATIONS CONTINUED (IF NECESSARY)**

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Schedule: \_\_\_\_\_ Will need at school: YES NO

**OTHER HEALTH INFORMATION CONTINUED (IF NECESSARY)**

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PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_