Campbell County School District #1

Nursing Services

School Nurses Campbell County

CONFIDENTIAL STUDENT HEALTH FORM

LAST:	FIRST:	MI:	Date of Birth:	Gender: ☐ M ☐ 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.

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

_____

_____

_____

_____

_____

_____

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)

_____

_____

_____

_____

_____

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____