Carman-Ainsworth Community Schools

Student Health Information

Part 1: Parent/Guardian to complete

Student Name: *(Last, First, M.I.)*	Sex: ☐ M ☐ F	DOB:	Grade:	School Year:
Home Phone: ( )	Father's Work/Cell Phone: ( )	Mother's work/cell phone: ( )		

My child has a medical condition that may affect his/her school day: ☐ No ☐ Yes (Please complete part 2)

My child is covered by health insurance: ☐ No ☐ Yes, Name of Insurance

Parent/Guardian Name (Please Print):

PARENT/GUARDIAN SIGNATURE: DATE:

Part 2: Please complete all that applies to your child. The parent/guardian is responsible for providing any medication, special food, and/or equipment that the student will require throughout the school day. Please see office staff for correct medication forms.

☐ **Allergies**

Allergy Type

☐ Food List Food(s): _____ ☐ Bee Sting ☐ Other:_____

Reactions

☐ Coughing ☐ Hives ☐ Rash ☐ Difficulty Breathing ☐ Nausea ☐ Wheezing

☐ Generalized Swelling ☐ Swelling ☐ Other_____

Treatments to be provided in school: ☐ Oral medications (Benedryl, etc.) ☐ Epi-Pen ☐ Other_____

☐ **Asthma**

Severity: ☐ Mild ☐ Moderate ☐ Severe

Triggers: ☐ Exercise ☐ Environmental ☐ Other_____

Symptoms or Reactions: ☐ Chest tightness, discomfort or pain ☐ Difficulty breathing ☐ Throat itch, tightness,

☐ Coughing ☐ Hoarseness ☐ Wheezing ☐ Other_____

Medications to be used in school: ☐ Inhaler ☐ Oral Medications ☐ Nebulizer

* **Please see office staff for *Asthma Action Plan* to be completed by parent/guardian and physician for every student with asthma.**

☐ **Diabetes**

Treatments to be provided in school: ☐ Insulin: ☐ Syringe ☐ Pump ☐ Pen

☐ Blood Sugar Testing ☐ Glucagon (need physician authorization) ☐ Oral Medications

* **Please see office staff or school nurse for *Diabetes Medical Management Plan* to be completed by parent/guardian and physician for every student with diabetes.**

☐ **Seizure Disorder**

Type of seizure: ☐ Absence ☐ Complex Partial ☐ Generalized Tonic-Clonic ☐ Other:_____

Physical Education Restrictions: ☐ No ☐ Yes (explain)_____

Medications needed in school: ☐ No ☐ Yes: List medication(s)_____

Date of last seizure: _____ Length of seizure: _____

* **Please see office staff or school nurse for *Seizure Care Plan* to be completed by parent/guardian and physician for every student with seizure disorder.**

☐ **Other Health Conditions**

☐ Cancer ☐ Hemophilia/Bleeding disorder ☐ Heart Condition ☐ Physical disability ☐ Other_____

Medication needed in school: ☐ No ☐ Yes List medication(s)_____

Special procedures needed in school (cardiac monitoring, etc.): ☐ No ☐ Yes (explain)_____

This information may be shared with teachers, bus drivers, etc., in order to promote the health and safety of your child.

Adapted from: Health Information for Fairfax County Public Schools
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