CAROLINE COUNTY PUBLIC SCHOOLS
STUDENT'S HEALTH HISTORY

School Year________________ Grade________ Teacher________________________________

Dear Parent, We would like for your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. **PLEASE complete both sides of this form and RETURN to the school nurse as soon as possible.**

Name____ Birth Date__________________ Sex: Male________________ Female ___________

Address____
911 Street Address City State Zip Code

Sibling(s) in Caroline County Schools (list student's name and school attending)____
____

Mother or Guardian____ Home Phone______________________ Work Phone________________

Address (if different from student's)____ Cell Phone_________________

Employer____

Father or Guardian____ Home Phone______________________ Work Phone________________

Address (if different from student's)____ Cell Phone_________________

Employer____

Child is in custody of: Mother_______ Father________ Both_________ Other____
(Write name here)

In case of an emergency, if parent/guardian cannot be reached, contact: **(This contact must be able to pick up child from school)**

Name____ Phone Number____

Name____ Phone Number____

Physician's Name______________________________________ Physician's Phone Number____________________________________

Dentist's Name____ Dentist's Phone Number_____________________________________

Is your child covered by medical insurance? Yes _______ No__________ if yes, check one: Medicaid__________ FAMIS_______ Other private carrier_________

If you do NOT have medical insurance, would you like information on Virginia's Insurance Program for Children? Yes_________________ No_________________

Would you like information on the Caroline County Dental Health Program? Yes __________ No __________

(OVER)

STUDENT NAME:________________________________ **GRADE:**_____________ **TEACHER:**____

Asthma yes____ no____
Arthritis yes____ no____
Blood Pressure Disorder yes____ no____
Cancer yes____ no____
Cerebral Palsy yes____ no____
Diabetes yes____ no____
Ear Problem/Hearing yes____ no____
Eating Disorder yes____ no____
Eczema yes____ no____

Emotional Disorder yes____ no____
Heart Condition yes____ no____
Hyperventilates yes____ no____
Menstrual Disorder yes____ no____
Migraine Headaches yes____ no____
Scoliosis yes____ no____
Seizures/Convulsions yes____ no____
Spina Bifida yes____ no____

Environmental Allergies (dust, mold, pollen, etc.) yes___no____
List other Allergies (food, nuts, bee stings, latex, etc.)__________
____
____
____
____

My child has the following prescribed:
Epi-pen yes____ no____
Benadryl yes____ no____
(Parent must provide all medications)

Date of last tetanus shot__________________________
Drug Allergies yes______ no____ Identify the drug and reaction____
List any medical conditions not listed____
Please explain any yes answer to the above and any accommodations you would like considered______________________
____

MEDICATIONS

Is your child taking any prescription or non-prescription medication? Yes______________________________ No______________________________
If yes, identify drug and the condition requiring the drug____
____

All medication administered by school personnel must be provided by the parent/guardian. The medication must be in the original container.
Prescription medication requires a physician's order and parent/guardian written consent.
Non-prescription medication requires parent/guardian written consent and a physician's order will be required if administered more than five days.
****Please note that this form is for information and does not give staff permission to administer medication. A separate medication request form is to be completed and may be obtained from your school or downloaded from the Caroline County Public Schools School website.***

yes____ no____ I give permission to share this information with my child's teacher(s) and other appropriate staff.
yes____ no____ I give permission for the school nurse to contact my child's physician when necessary.
yes____ no____ In the case of emergency, if I cannot be reached; I give permission for my child to be transported to the nearest hospital. The hospital and medical staff have my permission to provide treatment as deemed necessary by a physician for the well-being of my child.
Preferred Hospital____

yes____ no_____This information is correct to the best of my knowledge.

Parent/Guardian Signature____ Date______________________________

RETURN TO THE SCHOOL AS SOON AS POSSIBLE

Revised 05/14