Montgomery County Public Schools
Health Information Form
2018-2019

Dear Parent/Guardian: This form is needed to complete your student's registration. The information helps us meet the health care needs of your child. It may also help us determine the need for additional health services in our schools. **All medical information is confidential. See privacy statement below.** If your child's health condition should change, please notify the school nurse. Thank you for your assistance.

PLEASE FILL OUT BOTH SIDES OF THIS FORM IN BLACK or BLUE INK ONLY

STUDENT NAME:	BIRTH DATE:	SCHOOL:	GRADE/HOMEROOM:
PARENT/GUARDIAN CONTACT :	HOME PHONE #:	WORK PHONE #:	CELL PHONE #:
EMERGENCY CONTACT #1:	RELATIONSHIP:	PHONE #:	ALT PHONE #:
EMERGENCY CONTACT #2:	RELATIONSHIP:	PHONE #:	ALT PHONE #:

If I cannot be reached in an emergency, I understand my child will be transported to the hospital via EMS.

Hospital of choice: _____

Does your child have a regular dentist? ___ Yes ___ No

ALLERGIES:

___ FOOD _____
___ INSECTS _____
___ MEDICINE _____
___ LATEX
___ SEASONAL
___ OTHER _____

***Does any allergy require use of an emergency EPIPEN? ___ YES (requires an emergency action plan) ___ NO**

INSURANCE COVERAGE: Is your child covered by any of the following?

___ Private (Name of carrier) _____ ___ Medicaid ___ FAMIS ___ School insurance
___ Other ___None: Would you like to receive information on how to obtain health insurance? **___ YES ___ NO**

Equipment or aids used by your child: ___ Oxygen ___ Ventilator ___ Wheelchair __Walker ___ Other _____

Special medical procedures required by your child (***will require a physician order--please speak with the school nurse***):

___ Nebulizer ___ Blood sugar monitoring ___ Tube feeding ___ Catheter ___ Other _____

Current DIAGNOSED Health Problems and Treatment (Please check all that apply):

	**Asthma-*HAS TAKEN MEDICATION WITHIN PAST 2 YEARS*		Cystic Fibrosis
	~Does student use an inhaler? YES NO		Developmental Delays/Difficulties
	~Does student use a nebulizer? YES NO		Emotional/Mental Health Concerns
	**Diabetes: ___Type 1 ___Type 2		Eye Disease/Problems (not glasses)
	~Blood glucose monitoring via: CGM AccuChek		Hearing Impairment
	~Does student use an insulin pump? YES NO		Heart Problems
	~Does student take insulin via syringe? YES NO		High Blood Pressure
	**Seizures-*HAS HAD A SEIZURE WITHIN PAST 2 YEARS*		Hypoglycemia
	~Type of seizures _____		Kidney Disorders
	~What are seizures triggered by? _____		Liver Disease
	~Does student have Diastat ordered? YES NO		Muscle Disease/Disorder
	Attention Deficit/Hyperactivity Disorder		Neck/Spinal Injury
	Autism Spectrum Disorder		Sickle Cell Disease
	Brain Injury-Traumatic		Stomach or Digestive Disorders
	Cancer/Tumor		Thyroid Condition
	Celiac Disease		Other (specify):

Unless declined in writing, Asthma, Diabetes and Seizures require an action plan signed by both physician and parent/guardian in order to provide your child with more specialized care.

____ *I decline a medical plan of care for my child who has asthma, diabetes, and/or seizures (please initial).*

If necessary, please tell us more about the health problems you checked:

_____

_____

STUDENT NAME: _____ **BIRTH DATE:** _____

Please list any scheduled medication your child is currently taking, and indicate whether it is taken at home and/or at school.

Medication	Dosage	Time(s) Taken	Taken at Home	Taken at School

This section MUST be completed:

Will your child be participating in after-school (school-sponsored) activities, field trips or overnight school trips? ___ Yes ___ No
Will your child need a medical procedure or scheduled medications during these activities? ___ Yes ___ No
If yes, please list the medication and/or procedure and times it is to take place or be administered:

_____

***Please be advised that you are responsible for notifying the school nurse AND after-school sponsor of any changes in your child's medical condition. ***

NEW

Schools will be stocking the following over-the-counter (OTC) medications in the clinic. Please complete a medication permission form (available on MCPS website) for any medication you want school staff to administer to your child as needed.

- ***Acetaminophen***
- ***Ibuprofen***
- ***Diphenhydramine (Benadryl)***
- ***TUMS Antacid***
- ***Cough drops***
- ***Hydrocortisone cream***
- ***Lidocaine spray*** *(for pain relief of insect bites/minor burns)*
- ***Refresh eye drops***

PLEASE NOTE: OTC medications are for **occasional** use only. If your child takes OTC medication on a regular basis or needs a dose outside of package label directions, a doctor's order is ***required*** in order for school nurses to administer these medications, and the medication must be supplied by the parent/guardian.

If your child needs any other medication at school or during an after school activity, you will need to supply the medication and complete an MCPS Medication Permission Form (*available at school or online @ mcps.org under SCHOOL HEALTH*) signed by the parent and/or physician as described in the MCPS medication policy.

Deemed Consent/ Privacy Statement:

As a health care provider, we are required by Section 32.1-45.1 of the Code of Virginia, as amended to give you the following notice:
-If one of our health care professionals, workers, or employees should be directly exposed to your child's blood or body fluids in a way that may transmit a disease, you will be asked to have your child's blood tested for human immunodeficiency virus, Hepatitis B or C viruses. A physician or other health care provider will tell you and the exposed person the result of the test.
-If your child should be directly exposed to the blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus, Hepatitis B or C viruses. A physician or other health care provider will tell you and that person the result of the test.

By signing this form, I authorize the release of my child's medical information by the school system to authorized school personnel to benefit the health, safety, and educational progress of my child and to the physician(s) named on this form, the EMS, and/or the hospital provider involved in the emergency care of my child. I have read the Deemed Consent for HIV and/or Hepatitis B or C exposure on this form and I understand it.

Parent/Guardian Signature: _____ **Date:** _____

***If you have any questions regarding this form or comments about the information you put on this form, please contact your child's school nurse. ***