STAFFORD COUNTY PUBLIC SCHOOLS HEALTH SERVICES

SCHOOL HEALTH INFORMATION FORM

Name: _____ Birth date: Mo. ____ Day ____ Yr. _____
Last First Middle Name
Sex: Male____ Female ____
Parent or Guardian _____ Work Phone: _____
Last First Home Phone: _____
Home Address: _____ _____ Zip: _____
Person to call in case of an emergency if parent/guardian is not available:
Name: _____ Phone: _____

Please provide information relative to the following health concerns of your child and return to office.

____yes ____no	**Allergies: type _____**	**____yes ____no**	**Heart Disease**
____yes ____no	**Asthma**	**____yes ____no**	**Thyroid Disease**
____yes ____no	**Cancer : type_____**	**____yes ____no**	**Mental Health**
____yes ____no	**Cerebral Palsy**	**____yes ____no**	**Stomach/Intestine**
____yes ____no	**Ear/Nose/Throat**	**____yes ____no**	**Elimination (bowel or urination)**
____yes____ no	**Diabetes: type_____**		
____yes ____no	**Eye/Vision**	**____yes____ no**	**Seizure Disorder**
____yes ____no	**ADHD**	**____yes ____no**	**Spinal Disorder/Injury**
____yes____ no	**Hearing**	**____yes ____no**	**Other**

If yes to any of the above, describe condition and equipment necessary, also list and describe any condition not listed above.

_____
_____
_____

Surgical History

Describe any hospitalizations/surgeries/fractures:

_____
_____
_____
_____

Medications

<u>LIST ALL</u> PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TAKEN AT HOME AND SCHOOL. A separate permission form is required in order for medications to be given at school.

_____
_____
_____
_____

I consent to the release of this health information concerning my student ,_____ ,
to any Stafford County Public School staff who need to know this information for health and safety reasons when they are working with my student at school.

Parent/Guardian Signature _____Date _____