



Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

## HEALTH AND EMERGENCY INFORMATION

### HEALTH CARE CONTACTS

Health Care Provider/Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

In case of accident or serious illness, I request that school staff contact me. If I cannot be reached, I hereby authorize school staff to call the physician indicated above or make reasonable arrangements deemed to be in the best interest of the child.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

### STUDENT'S MEDICAL HISTORY (CHECK THOSE THAT APPLY):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADHD                         | <input type="checkbox"/> Dental Problem                 | <input type="checkbox"/> Kidney/Bladder Problems               |
| <input type="checkbox"/> ADD                          | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Menstrual Problems                    |
| <input type="checkbox"/> Allergy: Bee Sting           | <input type="checkbox"/> Disability - Physical          | <input type="checkbox"/> Orthopedic Condition                  |
| <input type="checkbox"/> Allergy: Food                | <input type="checkbox"/> Earaches/Infections - Frequent | <input type="checkbox"/> Seizure Disorder                      |
| <input type="checkbox"/> Allergy: Latex               | <input type="checkbox"/> Eczema                         | <input type="checkbox"/> Sore Throats - Frequent               |
| <input type="checkbox"/> Allergy: Medication          | <input type="checkbox"/> Fainting Spells                | <input type="checkbox"/> Speech Problem                        |
| <input type="checkbox"/> Allergy: Pesticide/Chemical* | <input type="checkbox"/> Gastrointestinal Disorder      | <input type="checkbox"/> Stomachaches - Frequent               |
| <input type="checkbox"/> Allergy: Seasonal            | <input type="checkbox"/> Headaches - Frequent           | <input type="checkbox"/> Vision Problem/Wears Glasses/Contacts |
| <input type="checkbox"/> Anorexia/Bulimia             | <input type="checkbox"/> Hearing Problem/Wears Aids     |  |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Heart Condition                |  |

If you have checked any of the above, please explain. Also include anything about your child's health that will help the school staff to better understand and work with him/her.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### DOES YOUR CHILD NEED MEDICATION FOR ANY CONDITION?

At Home:  Yes  No      At School:  Yes  No

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason Needed: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason Needed: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason Needed: \_\_\_\_\_

**Reminder: You must supply a medication form completed by a health care provider for each medicine the student takes at school.**

\* FCPS uses the Integrated Pest Management program to identify and control pest problems in schools. **Elementary** schools must notify staff and parents/guardians of all students 24 hours before pesticides are to be applied inside the school building or on the grounds. **Middle and high schools** must notify only those parents, guardians or staff who have filed a written request for notification; forms are available at each school and must be updated every school year. (See the FCPS Calendar Handbook for details, or contact your school.)

(Please complete other side)