



400 North Church Street
Monroe, NC 28112
www.ucps.k12.nc.us

Dear Parent/Guardian,

I am sending this letter to gather information about students who have health needs. Please fill out the reverse side of this form, "Request for Health Information," regardless of if your student has medical needs that could affect learning or might require emergency care during the school day. A health care provider's written diagnosis is required in order for an Individualized Healthcare Plan to be developed by the school nurse. Also, please let your school nurse know if your child participates in extracurricular school activities.

Chronic Health Conditions

- Please complete the reverse side of this form.
- If your child has a life-threatening condition/allergy, please notify the school nurse and any other staff members who will be in contact with your child (including afterschool care, cafeteria/bus driver/coach/extracurricular activities).
- Contact the school nurse if you need to schedule a conference to discuss details regarding the development of a health care plan for your child.
- Provide necessary changes that occur during the school year, either with contact numbers or your child's health condition.

Medication Administration

- Medication must be sent in the original container if it is an over-the-counter medicine or a prescription bottle if it is a prescription medicine.
- Please check expiration dates. School personnel are not allowed to give expired medications.
- The school does not provide any medications, including ointments, creams, pain relievers, eye drops, etc. Any medication given at school must be provided by the parent/guardian.
- A medication consent form is required for any medication given at school.
- **Signatures from a parent/guardian AND the student's health care provider are required for ANY medication to be given at school. This includes prescription as well as over the counter medications.**
- Faxed consents from parents and/or doctors are acceptable.
- The entire UCPS medication policy may be viewed online at www.ucps.k12.nc.us

If you have questions or concerns, please contact the school. I would be happy to speak with you.

Sincerely,

School Nurse

Request for Health Information

Date: _____

Must be completed annually

Please return the following form to your child's teacher as soon as possible. This information will be reviewed by the School Nurse.

| | | |
|---|--------------------|-------------------|
| School: | Grade: | Homeroom Teacher: |
| STUDENT NAME: | Date of Birth: | Bus# |
| Parent/Guardian: | Daytime Phone (1): | |
| Parent/Guardian email: | Daytime Phone (2): | |
| Emergency Contact: | Phone: | |
| Current Doctor/Practice: | Phone: | |
| Medication allergies and reaction(s): <input type="checkbox"/> NONE KNOWN <input type="checkbox"/> Yes (list): | | |
| Current Medications: | | |
| Meds needed at school?: <input type="checkbox"/> No <input type="checkbox"/> Yes* (list): <i>(*)Medication consent form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received.</i> | | |

CHECK THE CONDITION(S) YOUR CHILD HAS BELOW, OR

MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

| | | | |
|---|--|---|---|
| <input type="checkbox"/> ADD/ADHD (See Below) <input type="checkbox"/> Allergies, Severe (See Below) <input type="checkbox"/> Allergies, Seasonal <input type="checkbox"/> Asthma (See Below) <input type="checkbox"/> Autism <input type="checkbox"/> Cancer/Leukemia Date Diagnosed: _____ | <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Crohn's Disease/IBS <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes (See Below) <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Epilepsy/Seizures (See Below) <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Hearing Aid/Loss <input type="checkbox"/> Head Injury/Concussion Date Diagnosed: _____ <input type="checkbox"/> Heart Conditions Type: _____ <input type="checkbox"/> Hemophilia/Bleeding Disorder <input type="checkbox"/> Mental Health Diagnosis (See Below) Migraine Headaches | <input type="checkbox"/> Neuromuscular Disease <input type="checkbox"/> Orthopedic Disability <input type="checkbox"/> Renal/Kidney Disease <input type="checkbox"/> Juvenile Rheumatoid Arthritis <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Ulcers/Gastric Reflux <input type="checkbox"/> Other: _____ |
|---|--|---|---|

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

| | |
|--|--|
| Severe Allergies Notify your School Nurse IMMEDIATELY if anaphylaxis may occur. | What is your child allergic to? <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Milk <input type="checkbox"/> Eggs <input type="checkbox"/> Insect Stings <input type="checkbox"/> Other: _____ Is medication needed at school for allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes* If yes, name: _____ Location of Medication: <input type="checkbox"/> Carried by student* (requires self-carry form) <input type="checkbox"/> Classroom <input type="checkbox"/> Health Room Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs: <input type="checkbox"/> HIVES <input type="checkbox"/> SWELLING <input type="checkbox"/> DIFFICULTY BREATHING <input type="checkbox"/> OTHER: _____ |
| Asthma | Is medication needed at school for asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes* If yes, name: _____ Location of Medication: <input type="checkbox"/> Carried by student* (requires self-carry form) <input type="checkbox"/> Classroom <input type="checkbox"/> Health Room Date of last episode: _____ Triggers: <input type="checkbox"/> Environmental <input type="checkbox"/> Seasonal <input type="checkbox"/> Exercise induced <input type="checkbox"/> Upper respiratory infection <input type="checkbox"/> Other: _____ |
| Epilepsy/Seizures | Type: <input type="checkbox"/> Febrile Only <input type="checkbox"/> Convulsive <input type="checkbox"/> Non-Convulsive Date of last seizure: _____ Is emergency medication needed at school? <input type="checkbox"/> No <input type="checkbox"/> Yes* If yes, name: _____ |
| Diabetes | Type I <input type="checkbox"/> Type II <input type="checkbox"/> Diagnosis Date: _____ * Insulin by: <input type="checkbox"/> Pump <input type="checkbox"/> Injections CGM (i.e.: Dexcom): <input type="checkbox"/> No <input type="checkbox"/> Yes, Type: _____ Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed |
| ADD/ADHD Mental Health | Type: <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Other: _____ Medication used for treatment: _____ |

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and you cannot be reached, I give permission for the School Nurse to contact my doctor for further instructions on medications or care.

Signature of Parent/Guardian _____

Date _____