UCPS
UNION COUNTY PUBLIC SCHOOLS

School Health Office

400 North Church Street
Monroe, NC 28112
704-296-9898
704-282-2171
Sucps.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/updates that occur during the school year regarding your 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 UCPS Policy Manual

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

Sincerely,

School Nurse

7/2024 cs

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Request for Health Information

Must be completed annually

Date: _____

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): ☐ NONE KNOWN ☐Yes (list):		
Current Medications:		
Medications needed at school? ☐ No ☐ Yes* (list): _____ ***(*) 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. Consent form will be provided upon request.***		

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).

__**ADD/ADHD** (See Below)	__Cerebral Palsy	__Hearing Aid/Loss	__Neuromuscular Disease
__**Allergies, Severe** (See Below)	__Crohn's Disease/IBS	__**Head Injury/Concussion**	__Nosebleeds, frequent and/or severe
__Allergies, Seasonal	__Cystic Fibrosis	**Date Diagnosed:** _____	__Orthopedic Disability
__**Asthma** (See Below)	__**Diabetes** (See Below)	__Heart Conditions	__Renal/Kidney Disease
__Autism	__Down Syndrome	Type: _____	__Juvenile Rheumatoid Arthritis
__Cancer/Leukemia Date Diagnosed:	__**Epilepsy/Seizures** (See Below)	__Hemophilia/Bleeding Disorder	__Sickle Cell Anemia
	__Glasses/Contacts	__**Mental Health Diagnosis** (See Below)	__Ulcers/Gastric Reflux
		__Migraine Headaches	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? ☐ Peanuts ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Insect Stings ☐Other: _____ Is medication needed at school for allergies? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Classroom ☐ Health Room Date/Type Last Reaction: _____ Check the type of allergic reaction that occurs: ☐ Hives ☐ Swelling ☐ Difficulty Breathing ☐ Other: _____
Asthma	Is medication needed at school for asthma? ☐ No ☐ Yes* If yes, name: _____ Desired Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Classroom ☐ Health Room Date of last episode: _____ Check what is likely to cause an asthma flare: Triggers: ☐ Environmental ☐ Seasonal ☐ Exercise induced ☐ Upper respiratory infection ☐ Other:_____
Epilepsy/ Seizures	Type: ☐ Febrile Only ☐ Convulsive ☐ Non-Convulsive Date of last seizure: _____ Is emergency medication needed at school? ☐ No ☐ Yes* If yes, name: _____
Diabetes	Type I ☐ Type II ☐ Diagnosis Date: _____ * **Insulin** by: ☐ Pump ☐ Injections **CGM** (i.e.: Dexcom): ☐ No ☐ Yes, Type: _____ ***Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed***
ADD/ADHD Mental Health	Type: ☐ ADD ☐ ADHD ☐ Anxiety ☐ Depression ☐ Other: _____ Medication(s) 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**