UCPS
UNION COUNTY PUBLIC SCHOOLS

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.

Student Name:	Homeroom Teacher/Grade:	Bus#:
School:	**Date of Birth:**	Home Phone:
Parent/Guardian:		Daytime Phone:
Parent/Guardian:		Daytime Phone:
Emergency Contact:		Phone:
Current Doctor/Practice:		Phone:
Medication allergies and reaction(s): ☐ NONE KNOWN ☐ Yes (list):		
Current Medications:		
Does your child need medications 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.

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, Seasonal	__ Crohn's Disease/IBS	__ **Head Injury/Concussion**	__ Orthopedic Disability
__ **Allergies, Severe** (See Below)	__ Cystic Fibrosis	**Date Diagnosed:** _____	__ Renal/Kidney Disease
__ **Asthma** (See Below)	__ **Diabetes** (See Below)	__ Heart Conditions	__ Juvenile Rheumatoid Arthritis
__ Autism	__ Down's Syndrome	Type: _____	__ Sickle Cell Anemia
__ Cancer/Leukemia	__ **Epilepsy/Seizures** (See Below)	__ Hemophilia/Bleeding Disorder	__ Ulcers/Gastric Reflux
Date Diagnosed:_____	__ Glasses/Contacts	__ **Mental Health Diagnosis** (See Below)	__ Other:_____
		__ Migraine Headaches	

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: _____ 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: _____ Location of Medication: ☐ Carried by student***** **(requires self-carry form)** ☐ Classroom ☐ Health Room Date of last episode: _____ 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 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**