Given to Parent: IHP Request ____ Med Form ____ 504 Letter ____ Date: _____

SUMNER COUNTY SCHOOLS STUDENT HEALTH INFORMATION FORM
School Year 2018-19

Dear Parents/Guardians: Please complete the following information, FRONT & BACK, and return it as soon as possible. This information will only be shared with the necessary school personnel to maintain and promote the student's health/wellbeing.

Student Name: _____ Sex: Male / Female Date of Birth: _____

School: _____ Grade: _____ Homeroom or 1st Period Teacher: _____

School attended last year: _____

Student is a: Bus rider _____ (Bus number-AM _____ PM _____) Car rider _____ Drives _____ Other _____

Parents/guardians are responsible for providing ALL medications, including over-the-counter (OTC) medicines, for their children. All medications must be delivered to the school in person by the parent, guardian, or parent/guardian's adult designee.

If your child PRESENTLY HAS OR HAD, **IN THE LAST 2 YEARS ONLY**, any of the problems listed below, check "Yes" beside the health problem and explain in the space provided:

Disease/Condition	Yes	No	Please explain/elaborate here:
Diabetes			If yes, Type I or Type II? (please circle) Any medications?
Heart Problems			
Kidney or Urinary Problems			
Asthma **(in last 2 years)**			Is a rescue inhaler used? Y / N Other medications?
Psychological Concerns			If yes, please list current medications:
Stomach/Intestinal Problems			
Seizure Disorder			Type: Date of last seizure: Medications:
			Is Diastat prescribed? Y / N Has it ever been given? Y / N Date last given:
Life-Threatening Allergies			To what?
			Is an EpiPen® prescribed? Y / N Has it ever been used? Y / N Date last used:
			Is Benadryl given with the EpiPen®? Y / N
List All Other Known Allergies (i.e. Meds, Foods, Nuts, Bee Stings, etc.):			
Other Health Concerns:			

Does your child have a physical or mental impairment that significantly limits one or more major life activities? Y / N If Yes, please explain: _____

Does your child take medication regularly not listed above? Y / N If Yes, what? _____

Student's primary doctor: _____ Phone: _____

Student's dentist/orthodontist (if applicable): _____ Phone: _____

Your signature is an informed consent to share health history information with school staff on a need-to-know basis for emergency plans & health plans. Student health information, within the school setting, is limited to the information necessary to serve the student's education and health interests. Your signature gives the school nurse permission to communicate with your student's health care provider(s) regarding health concerns.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Home Phone: _____ Cell: _____ Work/Ext: _____

Parent e-mail address(es):