CARROLL COUNTY SCHOOLS STUDENT HEALTH NEEDS IDENTIFICATION FORM

Student Name:_____ Date of Birth: _____
Homeroom Teacher:_____ Grade: _____
Physician: _____ Phone Number: _____

Section 1: Medical History (mark your answer with an "X")

ADD	YES	NO	DIABETES*	YES	NO	KIDNEY PROBLEMS* (describe below)	YES	NO
ADHD	YES	NO	ECZEMA	YES	NO	MIGRAINES	YES	NO
ASTHMA* (complete Section 3)	YES	NO	EPILEPSY/SEIZURES*	YES	NO	NOSEBLEEDS	YES	NO
BLOOD DISORDERS* (describe below)	YES	NO	HEADACHES	YES	NO	SEASONAL ALLERGIES	YES	NO
CANCER*	YES	NO	HEART PROBLEMS* (describe below)	YES	NO	SEVERE ALLERGIES* (complete section 4)	YES	NO
Other medical problems not listed above or explanation of "YES" items listed above:								
For those items marked with an *, has an action plan been provided to the school? YES NO								

Section 2: Medications

All medication(s) that are listed to be taken at school must be provided by the parent and a Request for Administration of Medication Form completed. Medications should not be transported to school by student.
List any prescription medication(s) that your child is taking at home: _____
_____
List any medication(s) that your child will be taking at school: _____
_____

Section 3: Asthma Information

Current status of your child's asthma (Please check one): Mild _____ Moderate_____ Severe _____
Asthma Medication(s) taken: _____
Does your child require any medication at school for Asthma? Yes _____ No _____
Please identify the things that trigger an asthma episode for your child: _____
_____

Section 4: Severe Allergies Information

- ❑ FOOD: _____
- ❑ INSECT STING: _____
- ❑ LATEX
- ❑ MEDICATION: _____

Symptoms your child exhibits with allergic reaction:_____
_____
Medication(s) taken for allergic reaction: _____
Will your child require medication at school for this allergy? Yes _____ No _____

NOTE: IF EPIPEN IS USED, 911 WILL BE CALLED

Section 5: Medical Equipment and Procedures Requires at School (place an "X" if required)

Catheter Gastric Tube Feeding Nebulizer Treatments Oxygen Supplement Tracheostomy
Vagal Nerve Stimulator (VNS) Ventilator Wheelchair Walker

Section 6: Consent for Treatment

The undersigned parent/guardian of _____ does hereby grant to the school principal, assistant principal or any teacher having supervision of the above referred child the authority to obtain emergency medical treatment for such child. Such individuals above referred to are authorized and are granted full authority and power of attorney to act in my behalf to secure and authorize medical treatment as necessary as determined by such principal, assistant principal or teacher. I agree to hold harmless the Carroll County Board of Education and the principal or teacher exercising the authority granted hereby in securing and authorizing medical treatment of the above referred to child. I agree to be financially responsible for charges of the hospital and physician made pursuant to the exercise of this authority.

This is the _____ day of _____20_____. Signature: _____