Student Health Information Form
Wythe County Public Schools

School Name | Grade | Teacher Name | Date mm/dd/yyyy

Select School Name Here | Select Grade

Student Full Name Last, First, Middle

Student Gender

☐ Female ☐ Male

Student Mailing Address | City | State | Zip

Student's Date of Birth mm/dd/yyyy | County of Birth | State of Birth | Primary Spoken Language

Name of Mother/Legal Guardian

Phone (xxx)-xxx-xxxx | Work (xxx)-xxx-xxxx | Mobile (xxx)-xxx-xxxx

Name of Father/Legal Guardian

Phone (xxx)-xxx-xxxx | Work (xxx)-xxx-xxxx | Mobile (xxx)-xxx-xxxx

Emergency Contact Name

Phone (xxx)-xxx-xxxx | Work (xxx)-xxx-xxxx | Mobile (xxx)-xxx-xxxx

Describe any other important health-related information about child (ie feeding tube, hearing aid, oxygen support, etc...).

List any and all prescription medications that need to be administrated in an emergency situation, this does require an action plan.

List all and all herbal, over-the-counter medications that your child takes regularly.

Click here if you want to discuss confidential information with the school nurse or other school authority.

☐ No ☐ Yes

Student Health Insurance

☐ FAMIS ☐ FAMIS Plus (Medicaid) ☐ None ☐ Other

I authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw authorization form any time by contacting your child's school. When information is released from your child's record documentation of the disclosure is maintained on your child's health or scholastic record.

☐ Yes, I do authorize. ☐ No. I do not authorize.

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Chronic/Life Threatening Conditions** If there are chronic/life threatening conditions parent/legal guardian are responsible for providing the school with an action plan from your licensed medical provider or a signed release form so that the school nurse may obtain the action plan. A licensed medical providers order is required to self-carry epi-pen or inhalers. *****

Chronic/Life Threatening Conditions	**Yes**	**Comments**
Allergies (drugs, food, insects, latex, please list)		
Allergies (seasonal, please list)		
Asthma or breathing problems (with/without inhaler licensed medical provider diagnosed)		
Cystic fibrosis		
Diabetes		
Heart issues		
Seizures		
Other Health Conditions	**Yes**	**Comments**
Attention-Deficit/Hyperactivity Disorder		
Behavioral issues		
Bladder issues		
Bleeding issues		
Bowel issues		
Celiac/Gluten Intolerances		
Cerebral Palsy		
Dental issues		
Developmental issues		
Head injury, concussions		
Hearing issues, deafness		
Lead Poisoning		
Muscle issues		
Sickle Cell Disease (not trait)		
Speech issues		
Spinal injury		
Surgery		
Vision issues		
Oher issues not listed feel need to be disclosed		

Please provide the following information	**Name**	**Telephone**	**Date of Last Appointment**
Case Worker (if applicable)			
Dentist			
Pediatrician/primary care provider			
Specialist			

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

revised 03/10/2017