CUMBERLAND COUNTY SCHOOLS'
CONFIDENTIAL SCHOOL HEALTH FORM

Rev. 6/2017

(PLEASE UPDATE AS CONDITIONS OR INFORMATION CHANGES)

Student's Name: _____ School: _____

Homeroom Teacher: _____ Grade: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Home Number: _____

Cellular Number: _____ Work Number: _____ Other Number: _____

Parent/Guardian's Name: _____ Home Number: _____

Cellular Number: _____ Work Number: _____ Other Number: _____

Student's Home Address: _____ City: _____ NC ZIP: _____

Parent/Guardian: In order to best meet your child's needs please provide the following physician diagnosed health information. Place a check in the appropriate block below.

My Child Has:

- ☐ No known health concerns
- ☐ ADD/ADHD
- ☐ Allergies (Severe) List:_____ _____
- ☐ Asthma
- ☐ Autistic Disorders (ASD) including Asperger's Syndrome, PDD
- ☐ Blood Disorders not listed elsewhere: Chronic Anemia, Thalassemia
- ☐ Cancer, including Leukemia
- ☐ Cardiac Condition
- ☐ Cerebral Palsy
- ☐ Chromosomal Conditions (Genetic): including Down Syndrome, Fragile X, Trisomy 18
- ☐ Chronic Encopresis
- ☐ Chronic infectious diseases: including: Toxoplasmosis, Cytomegalovirus, Hepatitis B, Hepatitis C, HIV, Syphilis, Tuberculosis, etc.
- ☐ Concussion
- ☐ Cystic Fibrosis
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Eating Disorder: Anorexia or Bulimia
- ☐ Emotional/Behavior and/or Psychiatric Disorder other than ADD/ADHD
- ☐ Other Neuromuscular Mobility:___ Ambulatory or ___Non-Ambulatory
- ☐ Endocrine/Metabolic Conditions: Not otherwise listed
- ☐ Fetal Alcohol Syndrome
- ☐ Gastrointestinal Disorder: Crohn's, Celiac desease, IBS, gluten intolerante, etc.
- ☐ Hearing Loss
- ☐ Hemophilia
- ☐ Hydrocephalus
- ☐ Hypertension
- ☐ Hypo/Hyperthyroidism
- ☐ Integumentary (skin)
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Obesity (> 95% BMI)
- ☐ Orthopedic Disability (Permanent)
- ☐ Renal/Adrenal/Kidney conditions including Addison's
- ☐ Rheumatological conditions including Lupus, JRA, etc.
- ☐ Seizure Disorder/Epilepsy
- ☐ Sickle Cell Anemia
- ☐ Sickle Cell Trait (only)
- ☐ Spina Bifida (myelomeningocele)
- ☐ Substance Abuse
- ☐ Traumatic Brain Injury
- ☐ Visually Impaired (uncorrectable)
- ☐ Other Neurological Condition: _____ _____ _____

Short description of your child's health problem and how the health problem may affect your child's school work:

_____

_____

If child receives special education services, list area of exceptionality: _____

_____

_____

Does your child have a 504 Plan? ☐Yes ☐No

Has your child experienced a head injury of any kind (e.g., concussion) in the past year? ☐Yes ☐No

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ALLERGIES

- Has your child received medical attention requiring an injection following a bee sting, ingestion of food, medication, or exposure to latex (i.e., gloves)? ☐Yes ☐No Date of last allergic reaction: _____
- Was your child prescribed any allergy kit? ☐Yes ☐No If yes, name of medication: _____
- Does your child require emergency medication at school? ☐Yes ☐No

CURRENT MEDICATIONS: Please list all medications your child is currently taking.	DOSE/AMOUNT TAKEN	WILL MEDICATION BE NEEDED AT SCHOOL?
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

If your child needs medication during school hours:

1. Pick up a CCS Physician's School Medication Form at the school office. This form is to be completed by both the child's physician and the parent/guardian.

2. Prescription medications may be administered at school and must be in a pharmacy-labeled prescription bottle that matches the CCS Physician's School Medication Form.

3. A CCS Over-the-Counter Medication Form must accompany all over-the-counter medications and may not exceed (5) five school days.

4. Parent/Guardian **must** transport all medications to the school office and sign them in with the medication clerk. **Do not send medications with your child.**

5. Medications that need to be kept with the child must have a CCS Emergency Self-Medication Authorization Form completed by a physician. **The student's parent/guardian shall provide the school backup emergency medication that shall be kept at the student's school in the event of an asthma or anaphylaxis emergency.**

In case of emergency, parent/guardian will be called first. If the school is unable to reach parent/guardian he/she should call:

1st Emergency Contact: _____ Home Number: _____

Cellular Number: _____ Work Number: _____ Other Number: _____

2nd Emergency Contact: _____ Home Number: _____

Cellular Number: _____ Work Number: _____ Other Number: _____

Primary Physician: _____ Office Number: _____

Physician Address: _____ City: _____ State: _____ ZIP: _____

Specialist Physician: _____ Office Number: _____

Physician Address: _____ City: _____ State: _____ ZIP: _____

If unable to reach a parent/guardian or an emergency contact person in case of accident or serious illness, I authorize the sharing of information pertinent to my child's current condition between school nurse/staff and physician. I authorize the school to call the physician or make whatever arrangements deemed necessary.

Parent/Guardian Signature: _____ Date: _____