**Germantown Municipal Schools**

**Confidential Student Health Information Form**

|  |  |  |
| --- | --- | --- |
| **Student:** | **Grade:** | **School Year 20\_\_\_\_\_ - 20\_\_\_\_\_** |
| **School:** | **DOB: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_** | **Male or Female (circle one)** |

**General Information**

The request for identifiable health information will enable us to provide safe and appropriate health care if your child becomes ill or injured at school or on the bus. The information that you provide will be maintained confidentially and is limited to individuals that work with your child within the school setting with a legitimate need to know. If you have any questions or would like to discuss specific health issues, please call the school directly during school hours or call the Department of Coordinated School Health.

**Parent/Guardian Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** | **First Name** | **Relationship** | **Phone** |
|  |  |  |  |
|  |  |  |  |

**Physician Contacts**

|  |  |  |
| --- | --- | --- |
| **Physician Name**  | **Phone** | **Address** |
|  |  |  |
|  |  |  |

**Please review the following list and check any and all that apply**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ADHD |  | Type I Diabetes |  | Meningitis |  | **Procedure Below**: |
|  | Anemia |  | Type II Diabetes |  | Migraine Headache |  | Catheterization |
|  | Anxiety attack |  | Depression |  | Nosebleeds |  | Tube Feeding |
|  | Arthritis |  | Dialysis |  | Panic attacks |  | **Equipment Below**: |
|  | Artificial joints |  | Fractures (Skull) |  | Rheumatic Fever |  | Crutches |
|  | Artificial valves  |  | Heart Problems |  | Scoliosis |  | Walker |
|  | AsthmaIs rescue inhaler needed? \_\_\_\_Y \_\_\_\_\_N |  | Hemophilia |  | Seizures |  | Wheelchair |
|  | Autism/Asperger’s |  | High Blood Pressure |  | Sickle Cell Anemia |  | **Other equipment/procedures:** |
|  | Cancer |  | Kidney Problems |  | Stroke |  |  |
|  | Concussion Date:  |  | Leukemia |  |  |  |  |
|  | Cystic Fibrosis |  | Low blood pressure |  | Other |  |  |

|  |
| --- |
| Other, including health equipment/procedures please provide specific information: |
|  |

**ALLERGY INFORMATION: IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING? (Check any that apply and list the specifics)**

|  |  |
| --- | --- |
|  | Medication (list specifics) - |
|  | Food (tree nuts-peanuts-fish-milk/dairy – list specifics) - EpiPen required? \_\_\_\_\_yes \_\_\_\_\_no |
|  | Insects (bees-wasps-ants – list specifics) - EpiPen required? \_\_\_\_\_yes \_\_\_\_\_no |
|  | Latex |
|  | Other (list specifics) - |

Name additional medications (if any) your child takes to treat an allergic reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child routinely take medication at home? If yes, please list:**

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dose** | **Time Taken** |
|  |  |  |
|  |  |  |
|  |  |  |

\*As the parent/guardian, **I do** \_\_\_\_\_\_ **I do not** \_\_\_\_\_\_ give permission to release health information to appropriate school system staff.

**Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**