Radford City Public Schools
Health Information Form

School Year: _____ Grade: _____ School: _____ Teacher: _____

Dear Parent or Guardian:
In order to provide the best educational experience, school personnel must understand your child's health needs. Please complete this form and return it to the school nurse as soon as possible. All medical information is kept confidential. It is only shared with Radford City Public Schools Staff who are responsible for your child's care at school. If your child's health condition should change, please notify the school nurse. Thank you for your assistance.

Student's Last Name: _____ First: _____ Middle Initial: _____ Birth date: _____

Parent/Guardian_____ Phone: Home: _____Work: _____ Cell #: _____
Emergency Contact(s) _____ Phone: _____
Doctor Name: _____
***Please list any allergies to: Foods: _____ Bees/Insects: _____**
_____ Latex: _____
Are any of these allergies severe enough to require an **Epi-Pen?** Yes _____ No _____ (If an **Epi-Pen is required**, we must have a written and signed Medication Authorization Form from physician and signed by parent.)

Chronic, Recurring and Special Health Conditions (Please check any of the following that apply)

Anemia		Heart Problems and/or Disease	
Anxiety (excessive)		High Blood Pressure	
Arthritis		Hypoglycemia (Low Blood Sugar)	
***Asthma**		Intestinal Disorder	
Attention Deficit/Hyperactivity Disorder (ADD/ADHD)		Kidney Disease	
Autism		Lead poisoning	
Behavioral Problems		Mental Health Concerns	
Bladder Problems and/or wetting accidents		Muscular problems/disease	
Bone or Joint Disorders		Organ Transplant	
Bowel problems and/or accidents		Scoliosis	
Cancer, Tumors, Growths		***Seizures**	
Cerebral Palsy		Sickle Cell Disease	
Chronic Bronchitis		Skin Problems/Disease	
Cystic Fibrosis		Speech Problems	
Dental Problems		Spina Bifida	
Depression		Stomach Problems/Ulcer	
Development Delays/Problems		Thyroid Disease	
***Diabetes**		Vision Problems/Blindness	
Dizziness/Fainting Spells		Weight Problems	
Eating Disorders/problems		Medication Allergies (please list)	
Emotional Problems			
Frequent Headaches/Migraines			
Frequent Nosebleeds		Other Health Problem(s) (please list)	
Head or Spinal Injury			
Hearing Problems or Deafness			

***** Please talk with school nurse about completing a Healthcare plan and medication authorization form.

Please discuss any health problems you have checked (some health problems may require a healthcare plan at school. The school nurse will contact you if a plan is needed) _____
_____
_____
_____
_____ *****Complete Back of Form*****

____I would like to talk with the school nurse regarding the health status/care of my child (please list phone number and time of day you can be reached): _____

Equipment or aids used by your child: _____Glasses/Contacts _____Wheelchair _____Hearing Aid _____Crutches _____Walker other (please list): _____

Special medical procedures required by your child during the school day (nebulizer, blood sugar monitoring, tube feeding, catheterization, etc.) These may require a doctor's order- please consult with the school nurse:

_____
_____
_____

Medications taken by your child may cause side effects, allergic reactions, changes in personality and other problems. Please list all medications you child is taking at **Home** or at **School** (medications at school require written authorization from **parent** and **doctor**). Forms are available from school.

Medication	Dosage	Time(s) Taken	Taken at Home	Taken at School

Is your child covered by: ____Private Insurance ____ Medicaid _____FAMIS _____Has no insurance

_____ I would like the school nurse or a member of the FAMIS Outreach Project to contact me regarding enrolling my child into FAMIS. FAMIS is a state and federally funded health insurance program designed to cover children who do not qualify for Children's Medicaid and who do not have private health insurance. Medical, hospitalization, prescription, vision and dental services are provided by FAMIS.

Does your child see a dentist for regular dental care? Yes ___ No____

If yes, name of dentist: _____

If no, I would like information to assist me in locating dental services for my child. Yes___ No ___

I give permission for the school to contact my child's health care provider about the information on this form. Yes ____ No _____

Signature of Parent/Guardian completing Health Information Form:

Parent/Guardian: _____ Date: _____