

School _____

Year 2007-2008

Teacher _____

Grade _____

City Schools of Decatur Health Information Form

Student Name _____ Date of Birth ____/____/____ Gender ____ M ____ F

Parent/Guardian _____ Phone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Phone: Home: _____ Work _____ Cell: _____

Physician Name _____ Phone Number _____

If your child does not have a doctor, would you like help finding a doctor? ____ Yes ____ No

Insurance Carrier _____ Medicaid/Peachcare _____ Policy Number _____

MEDICAL HISTORY

Please check any condition that your child has had:

Illness/Conditions _____ None

- ADD/ADHD
- Asthma If yes, complete Asthma Care Plan
- Diabetes If yes, complete Diabetes Care Plan
- Depression
- Fainting Spells
- Headaches
- Heart Problems
- Kidney/Bladder Problems
- Skin Rashes
- Seizures If yes, complete Seizure Care Plan
- Sickle Cell Anemia
- Other

Is there anything else you'd like your School Nurse to know regarding the care and treatment of your child? Include on back.

Allergies _____ None _____

- Drugs _____
- Food _____
- Bee/insects _____ If yes, what type of reaction occurs? _____

Will your child need an Epipen at school? ____ Yes ____ No **If yes, must provide.**

I give consent for the School Health Program nurse to discuss medical information with my child's Health Care Provider.
____ Yes _____ No

In case of serious injury/illness, the school shall telephone the local Medical Emergency Unit (911) for immediate transport to hospital emergency room. Fees for transportation and medical services will be the responsibility of the parent/guardian.

Parent/Guardian Signature

Date

This form is distributed by the CSD/DeKalb Medical Center School Health Program. It is important we have accurate and updated medical information to address your child's health needs. Please return this form to the school nurse's office. Please contact us at (404) 370-4420 ext 157, if you have questions or concerns.

ALL HEALTH INFORMATION IS KEPT CONFIDENTIAL

