Henrico County Public Schools
STUDENT HEALTH HISTORY

Name:	DOB:	SEX: M or F
Sibling(s) at Henrico County schools/teacher(s):		
Legal Guardian 1.Name:		Relationship:
Phone :	Work Phone:	E-Mail
Legal Guardian 2..Name:		Relationship:
Phone :	Work Phone:	E-Mail
Emergency Contact:	Relationship:	Phone:
Emergency Contact:	Relationship	Phone:
Doctor's Name:	Doctor's Office Phone Number:	
Preferred Hospital:		
Dentist Name:	Dentist Office Phone Number:	

***When guardians and emergency contacts cannot be reached, the school nurse is required to contact appropriate authorities if necessary.**

Name of Medical Insurance:	☐ Medicaid	☐ Medicaid with HMO	☐ None	Other:

If you are interested in free or low cost health insurance click on or go to this link https://www.famis.org/

HEALTH PROBLEMS (PLEASE CHECK ALL THAT APPLY)

o Yes ADD/ADHD	o Yes Cystic fibrosis	o Yes Juvenile Arthritis
o Yes Allergies (not life threatening)	o Yes Diabetes: (fill in all that apply)	o Yes Kidney / Urinary tract disorders
o a. Seasonal o b. Other	o a. Type I o b. Type II	o Yes Mental health condition
o Yes Allergies/ Anaphylaxis (life threatening)	o a. Insulin o b. Glucose monitor	Diagnosis:
o Yes a. Food w/ Epi-pen Type of food:	o c. Insulin Pump o d. Glucagon	o Yes Migraine headaches (diagnosed)
o Yes b. Food w/o Epi-pen	o Yes Do Not Resuscitate Orders	o Yes Neurological condition
o Yes c. Insect w/ Epi-pen	o Yes Fainting	Diagnosis:
o Yes d. Insect w/o Epi-pen	o Yes Feeding tube / G tube	o Yes Oxygen dependent
o Yes e. Latex w/ Epi-pen	o Yes Headaches (not migraine)	o Yes Scoliosis
o Yes f. Latex w/o Epi-pen	o Yes Hearing impaired:	o Yes Seizures/convulsions
o Yes g. Other w/ Epi-pen	o a. Cochlear implant o b. Hearing aid	o Yes Sickle-cell anemia
o Yes h. Other w/o Epi-pen	o c. Sign language	o Yes Stomach/Bowel disorder
o Yes Asthma:	o d. Other:	Diagnosis:
o a. Inhaler		
o b. Nebulizer	o Yes Impaired Movement	
o c. Other:	o a. Wheel chair dependent	o Yes Tracheostomy
o Yes Autism Spectrum Disorder	o b. Prosthetics ¢ c. Crutches	o Yes Traumatic brain injury
o Yes Cancer (type)	o d. Other:	o Yes Ventilator Dependent
o Yes Cardiovascular disorder		o Yes Vision: glasses/contacts
o Yes Celiac disease		o Yes Other:

MEDICATIONS OR TREATMENTS-PLEASE LIST MEDICATIONS OR TREATMENTS THAT YOUR CHILD IS ON AND WHETHER IT IS NEEDED AT SCHOOL

Medication/ Treatment	Dose	Reason	Need at School	Doctor's Name	Doctor's Office Phone #
			Y or N		
			Y or N		
			Y or N		

X_____
Parent Signature

Date

Please Turn Over

***Parent/Guardian for the safety of your child, please provide any emergency medications prior to your child's arrival at school (Benadryl, Epi-pen, inhaler, nebulizer, other). *All medication administered during the school day must be provided to the school nurse by the parent/guardian in an unopened container (over-the-counter) or in a current prescription bottle with a current prescription label attached. Written parent permission and a doctor's order is required for prescription medication to be administered at school. See the HCPS website and school handbook for the full medication policy. http://www.henrico.k12.va.us/HealthNutrition/HealthServices/MedicationPolicy.html**

Submitting this form enables the school nurse to contact your child's health care provider for the sole purpose of obtaining required school health information to care for your child or to permit their attendance.

FOR NURSE USE ONLY:			
SCHOOL:	SCHOOL YEAR:	DATE:	GRADE/HR
TEACHER			

Note: If your child has any medical updates after submitting this form, please contact your child's school nurse.