Henrico County Public Schools
STUDENT HEALTH HISTORY

Name:		DOB:	SEX: ◯ M or F ◯
Home School	Second School (if applicable)		
Sibling(s) at Henrico County schools/teacher(s):			
Legal Guardian 1.Name:	Relationship:	Preferred Language	
Phone :	Work Phone:	E-Mail	
Legal Guardian 2.Name:	Relationship:	Preferred Language	
Phone :	Work Phone:	E-Mail	
Emergency Contact:	Relationship:	Phone:	Preferred Language
Emergency Contact:	Relationship:	Phone:	Preferred Language
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.coverva.org/famis/

HEALTH PROBLEMS (PLEASE CHECK ALL THAT APPLY)

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

MEDICATIONS OR TREATMENTS-PLEASE LIST MEDICATIONS OR TREATMENTS THAT YOUR CHILD IS ON AND

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

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.henricoschools.us/health-safety/**

☐ **I give permission for the school nurse to contact my child's health care provider regarding medical care needs and medications at school.**

***** Section 504 of the Rehabilitation Act of 1973 ensures that persons with certain physical or mental impairments are entitled to equal access to services and programs offered to classmates in HCPS. If you have additional questions regarding your student's potential rights under Section 504, please contact your school administrator. Our current handbook can be located at henricoschools.us/section-504.**

Are there any considerations that we should know about related to your religious beliefs/practices – diet, prayer/meditation times, fasting, etc.?

_____

_____

_____

_____

_____

_____

X_____

Parent Signature **Date**

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.