Cherokee County School District

STUDENT HEALTH NEEDS IDENTIFICATION FORM

THIS FORM IS TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN AND RETURNED TO THE SCHOOL NURSE

STUDENT'S NAME_____

HOMEROOM TEACHER_____ D.O.B. _____

SIBLING(S) ENROLLED IN CCSD: GRADE _____

TEAM _____

Name _____ Grade_____ School _____

Name _____ Grade_____ School _____

Name _____ Grade_____ School _____

PARENT/LEGAL GUARDIAN _____

HOME PHONE _____ CELL PHONE_____ WORK PHONE_____

PHYSICIAN_____ PHYSICIAN'S PHONE_____

Is your child allergic to any medications? YES No If yes, please list_____

MEDICAL HISTORY: Please check below if your child has now or has had in the past:

	NOW	PAST		NOW	PAST
Asthma treated with daily medication			Nosebleeds		
Diabetes			Respiratory problems		
Seizures/Epilepsy			Cancer		
Heart Problems			Kidney problems		
Headaches			Blood disorders		
Skin diseases			Other:		
*Allergies (see below)			Other:		

Please describe other medical problems: _____

Does your child have any physical, hearing or visual disability? Yes No

If yes, please describe: _____

Does your child have a medical procedure that must be performed during the school day? Yes No

If yes, please list: _____

*Does your child have allergies to food or insects? Yes No

If yes, please list: _____

*Has your child experienced an anaphylactic reaction in the past (including, but not limited to, difficulty breathing or shock)? Yes No

*Has an emergency epinephrine injector been used on your child due to an anaphylactic reaction? Yes No

If yes, please describe the circumstances: _____

List any medication(s) your child is taking that the school nurse and/or staff should be aware of:

_____

The school cannot administer any medication until a medication authorization form has been completed for each medication. Medication must be provided by a parent/legal guardian.

_____ _____

Parent/Legal Guardian Signature Date