DEKALB COUNTY SCHOOL DISTRICT
STUDENT HEALTH INFORMATION
School Year (2023 to 2024)

Student's Name_____

Male or Female (please circle one) **Birth Date**: _____ **Grade:** _____

School: _____ **Date**_____

Please check any of the following that applies to the student: *Please provide documentation from your healthcare provider to confirm each diagnosis/symptom checked.

_____**ADD**
_____**ADHD**
_____**Allergies; Specific type**_____
Is EpiPen required? Yes ___ No___
_____**Asthma**
_____**Reactive Airway**
_____**Frequent Bronchitis**
_____**Chemotherapy / Immunosuppression**
_____**Cystic Fibrosis**
_____**Depression**
_____**Diabetes: Type 1___ Type 2____**
_____**Eating Disorder**
_____**Underweight**
_____**Overweight**
_____**Head Injuries**
_____**Hearing Loss**
_____**Heart Disease**
_____**Hemophilia**
_____**Hepatitis**

_____**Hypertension**
_____**Injury, Major**
_____**Kidney Disease**
_____**Leukemia**
_____**Nosebleeds (frequent)**
_____**Organ Transplant**
(Please circle) Liver /Heart /Kidney
_____**Orthopedic Problems**
_____**Migraine Headaches**
_____**Muscular Dystrophy**
_____**Pityriasis Rosea**
_____**Pneumonia**
_____**Psoriasis**
_____**Rheumatic Fever**
_____**Seizure Disorder**
_____**Sickle Cell Anemia / Trait**
_____**TB**
_____**Vision Loss**
_____**Other**_____

If this student has any of the above, did he/she receive medical care? Yes____ No____

Is the student under medical treatment now? Yes___ No_____

If yes, what kind of medical treatment? _____

Is the student on any kind of medication(s)? Yes____ No_____

If yes, please list medication(s) _____

_____

NOTE: Please see the school health personnel for a Physician Request for Administration of Medication.
A physician/health care provider MUST sign a form for EACH medication to be taken in school.

Parent /Guardian Signature **(Phone Number)**

THIS INFORMATION IS CONFIDENTIAL. PLEASE RETURN FORM TO CLINIC AT YOUR SCHOOL.

***Please turn over and complete the form**

_____

EMERGENCY CONTACT INFORMATION

Father/Guardian _____ **Phone** (H) _____ (C) _____
Print Name
Phone (W) _____

Mother/Guardian _____ **Phone** (H) _____ (C) _____
Print Name
Phone (W) _____

If parents cannot be reached, list two nearby persons who will assume care of your child.

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Child's Healthcare Provider _____ **Phone** _____

I give permission to contact my child's healthcare provider for further medical information. Yes ____ No _____

I also understand that in the event of an emergency, and I cannot be reached, that the school will have my child transported to the hospital via the EMS/911 service to receive appropriate treatment.

Parent Signature: _____ **Date:** _____

Revised 6/30/22