



PULASKI COUNTY PUBLIC SCHOOLS

Pathway to a Brighter Tomorrow

Transportation:
_____ Walker
_____ Car Rider
_____ Bus #
_____ Driver

Health Information Form

School Year: **2025-26** School: _____ Current Grade: _____

Dear Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. Please complete this form and return it to the school nurse within the 1st week of school. All medical information is kept confidential. It is only shared with Pulaski County School Staff who are responsible for your child's care at school. **Your child will not be allowed to participate in field trips, sports or other extracurricular activities until the school nurse has this signed and completed form on file in the school clinic.**

Student's Name: _____ Birth date: _____

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

Emergency Contact(s) _____ Phone: _____

Doctor Name: _____

My child has the following allergies: *Foods: _____ Epi Pen needed Yes No
 *Bees/Insect: _____ Epi Pen needed Yes No
 *Latex: _____ Epi Pen needed Yes No

***All food allergies require a note from a physician. Any allergy requiring medication must have a care plan.**

Please check any of the following that apply to your child's health.

**Asthma	Hearing Problems/deafness	
Inhaler/Nebulizer Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aid needed <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attention Deficit/Hyperactivity Disorder (ADD/ADHD)	Hypoglycemia (low blood sugar)	
Anemia/Bleeding Problems	Blood sugar monitoring needed <input type="checkbox"/> Yes <input type="checkbox"/> No	
Autism	Lead Poisoning	
Behavioral Problems	Kidney Disease/transplant	
Bladder/ Problems and/or wetting accidents	Mental Health Concerns	
Bone/ Joint Disorders/Muscle Problems	**Seizures	
Bowel problems and/or accidents	Scoliosis	
Cancer	Sickle Cell Disease	
Cerebral Palsy	Skin Problems/Disease	
Cardiac/Heart Problems/Hypertension	Speech Problems	
Cystic Fibrosis	Spina Bifida/Spinal injury	
Dental Problems/Cavities	Stomach/Intestinal Problem	
Depression	Sleep apnea	
Developmental Delays/Problems	Seasonal Allergies	
**Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	Thyroid Disease	
Dizziness/Fainting Spells	Weight Problems	
Eating Disorders/problems	Vision Problems/blindness	
Emotional Problems	Glasses <input type="checkbox"/> Contacts <input type="checkbox"/>	
Frequent headaches/Migraines	Medication Allergies: (please list)	
Frequent Nosebleeds	Other Health Problems (please list)	
Head injury/concussions		

**** Asthma, Allergies, Diabetes, and Seizures require an action plan signed by both physician and parent/guardian.**

Please complete and sign page 2 and return to school nurse ASAP.

Please discuss any health problems and/or special medical procedures you have checked (some health problems may require Medication Administration at school and/or a written health care plan. The school nurse will provide you with the needed Medication Authorization Forms and/or care plans)

Check here if you want to talk with the school nurse about your child's health concerns. Yes No

Medications taken by your child may cause side effects, allergic reactions, changes in personality and other problems. Please list all prescription, over-the-counter, and herbal medications your child is taking at **Home** or at **School** (**medications at school require written authorization from parent and doctor**). Forms are available at your child's school.

List of medications	Dosage	Time(s) Taken	Taken at Home	Taken at School

Does your child have: Private Insurance Medicaid FAMIS Dental Insurance Have no health insurance

Does your child have a family physician? Yes (Name/# of provider) _____

No

Does your child have a regular dentist? Yes (Name/#of dentist) _____

No

Would you like information about the dental and medical programs offered by the School Based Health Center located at PCHS? (Available for all PCPS students) Yes No

FAMIS is a state and federally funded health insurance program designed to cover children who do not qualify for Children's Medicaid and who do not have private health insurance. Medical, hospitalization, prescription, vision and dental services are provided by FAMIS. If you have questions or would like to sign up for FAMIS you can call toll free 1-855-242-8282, or visit www.coverva.org for more information or to apply online. You may also apply at your local Department of Social Services.

Signature of Parent/Guardian completing Health Information Form:

Parent/Guardian: _____ Date: _____

Parent Email Address: _____

****If your child's health condition should change, please notify the school nurse. Also please remember to notify the school nurse if your phone numbers change.**

Reviewed: June 1, 2025