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

<u>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.</u>

Reviewed: June 1, 2025