Student Health Information (High School)

Student Name:	**Date of Birth:**
School: East Chapel Hill High School	**Grade (2023-2024):**
Parent/Guardian Contact Information Please print	**Parent/Guardian Contact Information Please print**
name	name
address	address
daytime phone	daytime phone
email	email
signature/date	signature/date

Please note:

- Should it be necessary for your child to receive medications at school (prescription or over-the-counter), a Medication Authorization form must be completed and returned to the nurse. Forms can be obtained on-line or from the school nurse. Medication must be brought to school by a parent in original, pharmacy-labeled container.
- If your child requires attention for a known medical issue during the school day, please contact the school nurse.
- Health information will be entered into the PowerSchool student database until you request otherwise.
- Please complete the following to provide health information about your child to school personnel. Health information is considered confidential; however, information on this form may be shared with teachers having direct contact with your child in order to provide a safe environment while your child is at school or engaged in school activities.
- In the event of an emergency, school personnel will call 911 and transport your child to the nearest hospital.

IF YOUR CHILD DOES NOT HAVE ANY KNOWN HEALTH CONDITIONS AND/OR YOU DO NOT HAVE ANY EMERGENCY CONTACT INFORMATION CHANGES TO REPORT, YOU DO NOT NEED TO RETURN THIS FORM.

PLEASE NOTE ANY HEALTH CONDITIONS AND PROVIDE UPDATED CONTACT INFO BELOW:

Friend, co-worker or nearby relative who will assume temporary care of your student if you cannot be reached

Name_____Phone_____

Healthcare Provider

Name_____Phone_____

Important Medical Information (please check):

_____ No known health concerns

_____ Allergies To what?_____ Life threatening? ▢ Yes ▢ No Epipen? ▢ Yes ▢ No

_____ Arthritis

_____ Bleeding disorders

_____ Diabetes ▢ Type 1 ▢ Type 2

_____ Heart problems

_____ Seizures, Last seizure?_____

_____ Vision ▢ glasses ▢ contacts

_____ ADHD

_____ Asthma, Last use of inhaler?_____

_____ Concussion within the last 12 months (date _____)

_____ Headaches (frequent or severe)

_____ Orthopedic Problems

_____ Sickle Cell

Other (list):_____

Does your student need a health/emergency Plan for any of the above health conditions: ▢ **Yes** ▢ No

Health Insurance (optional)**:** ▢ Private ▢ Medicaid ▢ Other ▢ None

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