Montgomery County Public Schools
Health Information Form
2021-22

All medical information is confidential. See privacy statement page 2. If your child's health condition changes, please notify the school nurse.

*****IF COMPLETING A PAPER FORM, PLEASE USE BLACK or BLUE INK ONLY*****

STUDENT NAME:	BIRTH DATE:	SCHOOL:	GRADE/HOMEROOM:
PARENT/GUARDIAN CONTACT :	HOME PHONE #:	WORK PHONE #:	CELL PHONE #:
EMERGENCY CONTACT #1:	RELATIONSHIP:	PHONE #:	ALT PHONE #:
EMERGENCY CONTACT #2:	RELATIONSHIP:	PHONE #:	ALT PHONE #:

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

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

If I cannot be reached in an emergency, I understand my child will be transported to the nearest hospital via EMS.

INSURANCE COVERAGE: Is your child covered by any of the following?

___PRIVATE (Name of carrier) _____ ___MEDICAID ___FAMIS ___SCHOOL INSURANCE

___NONE: Would you like to receive information on how to obtain health insurance? ___YES ___NO

EQUIPMENT OR AIDS USED BY YOUR CHILD: ___OXYGEN ___VENTILATOR ___WHEELCHAIR ___OTHER _____

SPECIAL MEDICAL PROCEDURES required by your child (***will require a physician order--please speak with the school nurse***):

___NEBULIZER ___BLOOD SUGAR MONITORING ___TUBE FEEDING ___CATHETER ___OTHER _____

ALLERGIES:

___FOOD _____

___INSECTS _____

___MEDICINE _____

___LATEX

___OTHER _____

Does any allergy require use of an emergency EPIPEN? ___YES (requires an emergency action plan) ___NO

Does student self-carry EPIPEN? ___YES ___NO

CURRENT DIAGNOSED HEALTH PROBLEMS AND TREATMENT (Please check all that apply):

	****Asthma**-*HAS TAKEN MEDICATION WITHIN PAST 2 YEARS*		Attention Deficit/Hyperactivity Disorder
	~Does student use an inhaler? ___YES ___NO		Autism Spectrum Disorder
	~Does student self-carry inhaler? ___YES ___NO		Brain Injury/Concussions
	~Does student use a nebulizer? ___YES ___NO		Cancer
	****Diabetes**: __Type 1 ___Type 2		Celiac Disease
	~Blood glucose monitoring via: ___CGM ___AccuChek		Developmental Delays/Difficulties
	~Does student use an insulin pump? ___YES ___NO		Emotional/Mental Health Concerns
	~Does student take insulin via syringe? ___YES ___NO		Eye Disease/Problems (not glasses)
	~Does student self-manage per their DMMP? __YES __NO		Hearing Impairment
	****Seizures**-*HAS HAD A SEIZURE WITHIN PAST 2 YEARS*		Heart Condition
	~Type of seizures: _____		Intra-cranial Shunt
	~What are seizures triggered by? _____		Neck/Spinal Injury
	~Does student have Diastat ordered? __YES __NO		Ostomy (colostomy/urostomy/ileostomy)
	Other (specify):		

****Unless declined in writing, Asthma, Allergies requiring EPIPEN, Diabetes and Seizures require an action plan signed by both physician and parent/guardian in order to provide your child with more specialized care.**

____ I decline a medical plan of care for my child who has asthma, life-threatening allergies, diabetes, and/or seizures. (initial)

If necessary, please tell us more about the health problems you checked:

_____

_____

STUDENT NAME: _____ **BIRTH DATE:** _____

Please list any scheduled medication your child is currently taking, and indicate whether it is taken at home and/or at school.

Medication	Dosage	Time(s) Taken	Where Taken
			___ HOME ___ SCHOOL
			___ HOME ___ SCHOOL
			___ HOME ___ SCHOOL
			___ HOME ___ SCHOOL

I give my permission for the following over-the-counter (OTC) medications to be administered by the school nurse as needed, according to package directions and based on age/weight:

Ibuprofen**……..**	**___YES**	**___ NO**
Allergy relief medication (cetirizine/Zyrtec)**.....**	**___YES**	**___ NO**
Acetaminophen**……..**	**___YES**	**___ NO**
Anti-itch spray/cream (hydrocortisone)**.....**	**___YES**	**___ NO**
Cough drops**……..**	**___YES**	**___ NO**
TUMS Antacid**……..**	**___YES**	**___ NO**
Saline eye drops**……..**	**___YES**	**___ NO**
Vaseline**……..**	**___YES**	**___ NO**
Burn/Sting relief spray (lidocaine) ……	**___YES**	**___ NO**
Antiseptic wash**……..**	**___YES**	**___ NO**

PLEASE NOTE: OTC medications are for ***occasional*** use only. If your child takes OTC medication on a regular basis or needs a dose outside of package label directions, a doctor's order is ***required*** in order for school nurses to administer these medications, and the medication must be supplied by the parent/guardian. **School staff, other than the nurse, may not administer these medications from the school's supply of medications; therefore school-supplied OTC medications will not be sent on field trips.**

If your child needs other medication or medical treatment during school or after-school activities, please notify your school nurse. The parent/guardian will need to supply the medication in its original container and complete an MCPS Medication Permission Form for <u>each</u> medication (available at school or online @ mcps.org under SCHOOL HEALTH). For after-school activities, please provide the nurse with medication at least <u>3 days in advance</u>.

Please be advised that you are responsible for notifying the school nurse AND after-school sponsor of any changes in your child's medical condition.

<u>DEEMED CONSENT/PRIVACY STATEMENT:</u>

As a health care provider, we are required by Section 32.1-45.1 of the Code of Virginia, as amended to give you the following notice:
-If one of our health care professionals, workers, or employees should be directly exposed to your child's blood or body fluids in a way that may transmit a disease, you will be asked to have your child's blood tested for human immunodeficiency virus, Hepatitis B or C viruses. A physician or other health care provider will tell you and the exposed person the result of the test.
-If your child should be directly exposed to the blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus, Hepatitis B or C viruses. A physician or other health care provider will tell you and that person the result of the test.

By signing this form, I authorize the release of my child's medical information by the school system to authorized school personnel to benefit the health, safety, and educational progress of my child and to the physician(s) named on this form, the EMS, and/or the hospital provider involved in the emergency care of my child. I have read the Deemed Consent for HIV and/or Hepatitis B or C exposure on this form and I understand it.

Parent/Guardian Signature: _____ **Date:** _____

***If you have any questions regarding this form or comments about the information you put on this form, please contact your child's school nurse.

MCPS 3.2021