GLENFOREST HEALTHROOM INFORMATION LETTER

2021-2022

Student Name_____Birthdate_____

Address_____City/State_____

Male_____ Female____ Home Phone_____

Student lives with (circle one): Mother Father Both Parents Other

Mother's/Legal guardian name_____

Address_____City/State_____

Home #_____Work #_____Cell #_____

E-MAIL Address_____

Father's/Legal guardian name_____

Home #_____Work #_____Cell #_____

E-MAIL Address_____

Doctor_____Phone #_____Fax#_____

Dentist_____Phone #_____

PREFERRED HOSPITAL_____

LIST 2 AUTHORIZED PEOPLE TO ASSUME RESPONSIBILITY AND PICK UP YOUR CHILD IN CASE OF AN EMERGENCY/ILLNESS WHEN THE PARENT/LEGAL GUARDIAN CANNOT BE REACHED

1. **Name_____Relationship_____**

Address_____City/State_____

Home #_____Work#_____Cell #_____

2. **Name_____Relationship_____**

Address_____City/State_____

Home #_____Work #_____Cell #_____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Please check( ) and explain any health condition DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER(Doctor or Nurse Practitioner)

CHECK	CONDITION	EXPLAIN
	ADD/ADHD	(CURRENT MEDICATION)
	ALLERGIES SEVERE REQUIRING AN EPI-PEN (2 Extra should be kept at school)	___Food: ___Insects: ___Seasonal:
	ANEMIA (LOW BLOOD)	
	ASTHMA (Inhalers should be available at school with completed medication forms on file)	Medication: Last Attack:___/___/____
	BLADDER/URINARY CONDITION	
	BONE/ORTHOPEDIC CONDITION	
	DIABETES Medication:	
	EPILEPSY(SEIZURES)	Last Episode:___/___/___Medication:
	FAINTING SPELLS(Syncope)	
	GENETIC CONDITION	
	HEART TROUBLE	Corrected: Y/N
	HEMOPHILIA/BLEEDING DISORDER	
	HIGH BLOOD PRESSURE	
	MENTAL HEALTH ILLNESS	DIAGNOSIS:
	PROBLEMS WITH VISION	GLASSES: Y/N last exam__/__/__
	PROBLEMS WITH HEARING	HEARING AID: Y/N EAR: __right__left
	REACTIVE AIRWAY DISEASE	
	SICKLE CELL	Last Crisis:__/__/__Last hospitalization:
	SKIN DISORDER	
	TUBERCULOSIS (TB)	
	OTHER:	

Does your child take any daily medications? __NO__YES- List medication and dosage:

_____

Medication given at: __ Home __School __Only in Emergency

Medication should be brought to the health room in its original container and the appropriate forms should be completed prior to a student receiving medicine at school. Parental consent is required for non-prescription medication and both parental and student's healthcare provider(Physician) signatures are REQUIRED for prescription medication.

****I GIVE THE SCHOOL NURSE PERMISSION TO CONTACT THE LICENSED PRESCRIBER AND/OR SHARE THE ABOVE INFORMATION WITH THE SCHOOL STAFF AS NECESSARY FOR MEETING MY CHILD'S EDUCATIONAL NEEDS.**

PAENT/LEGAL GUARDIAN'S SIGNATURE_____DATE_____