

# CONFIDENTIAL HEALTH AND EMERGENCY INFORMATION

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

## HEALTH CARE CONTACTS

Health Care Provider/Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance [  ] Yes Health Insurance Company: \_\_\_\_\_ [  ] No

## STUDENT'S MEDICAL HISTORY (Please check or complete information that applies):

Contact school nurse to set up a care plan for your child.

### Allergies:

### Briefly Describe Reaction:

<input type="checkbox"/> Medications (Specify) _____	_____
<input type="checkbox"/> Foods (Specify) _____	_____
<input type="checkbox"/> Latex _____	_____
<input type="checkbox"/> Bees _____	_____
<input type="checkbox"/> Pesticide/Chemicals* _____	_____
<input type="checkbox"/> Other (Specify) _____	_____

### Chronic Health Condition(s) and Comments:

Asthma \_\_\_\_\_

Seizure Disorder \_\_\_\_\_

Diabetes \_\_\_\_\_

Other (Specify) \_\_\_\_\_

### Additional History and Comments:

Hearing Problems (Specify) \_\_\_\_\_

Vision Problems (Specify) \_\_\_\_\_

Physical Disabilities (Specify) \_\_\_\_\_

Other (Specify) \_\_\_\_\_

### Medications: (please list)

### Medical Condition Treated:

_____	_____
_____	_____
_____	_____
_____	_____

Health care provider/physician and parent **must** complete the appropriate authorization form(s) if medications or treatments are required at school. These forms may be obtained from the health staff at your child's school or at <http://www.fcps.org/> (then click on "Forms").

\* FCPS uses the Integrated Pest Management program to identify and control pest problems in schools. **Elementary** schools must notify staff and parents/guardians of all students 24 hours before pesticides are to be applied inside the school building or on the grounds. **Middle and high schools** must notify only those parents, guardians or staff who have filed a written request for notification; forms are available at each school and must be updated every school year. (See the FCPS Calendar Handbook for details, or contact your school.)

**IMPORTANT:** The information I have provided regarding my child's health may be shared with FCPS/Frederick County Health Department staff as appropriate. In case of accident or serious illness, I request that school staff contact me. If I cannot be reached, I hereby authorize school staff to call the physician indicated below or make reasonable arrangements deemed to be in the best interest of the child.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_