SCHOOL HEALTH INFORMATION

Student Name_____Date_____

School_____Grade/Teacher/Track_____

Special Ed Learning Center ☐

Special Ed Functional Skills ☐

☐ **NO HEALTH CONCERN**

Do you feel your student needs a plan of care (helps guide faculty and staff in meeting the needs of your student) on file at the school?

Yes ☐ No ☐

HEALTH CONCERN(S):

Allergy to:_____ EPI-PEN_____ Benadryl_____

Seizure_____ Diabetes_____ Glucagon at school_____

Asthma_____ Inhaler with student_____ Inhaler in office_____

Other_____

_____

Severity of Condition: (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

Medications needed at school? ☐ **YES** ☐ **NO**

Name of Medication/s:_____Dose_____ Time_____

_____Dose_____ Time_____

How to manage health concern/s at school:

_____

_____

_____

INFORMED CONSENT

I understand that my student's health information will need to be shared:

1. To benefit the student in terms of health maintenance and academic progress
2. When necessary to accommodate the safety and well being of students and staff
3. With the discretion of the School Nurse to determine what is shared and who should know

I understand that consent for sharing of health information will remain in effect as long as student is enrolled in Davis School District and may be revoked at anytime in writing by parent/guardian.

I understand if clarification of the health information is needed that my signature:

1. Authorizes the School Nurse to contact the medical provider
2. Authorizes the medical provider to release information

Parent / Guardian Signature:_____ Date:_____

Phone Numbers: _____

Nurse Signature:_____ Date:_____