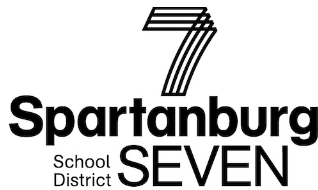

STUDENT HEALTH FORM
2019-20

____ ☐ Male ☐ Female
Student's First Name Middle Name Last Name

Birthdate ________________ Grade _______________ Teacher ____________________________________Medicaid #________________________________

Home Address ____Home Phone ______________________________

Email Address____

Mother/Guardian ____________________________________ Work Phone _____________________________Cell Phone _______________________________

Father/Guardian ____________________________________Work Phone _____________________________Cell Phone _______________________________

Please list three people who could pick your child up from school in case of accident or illness if you cannot be reached.

Emergency Contact Name ____ Phone ____

Emergency Contact Name ____ Phone ____

Emergency Contact Name ____ Phone ____

Preferred Hospital in an Emergency: ☐ Spartanburg Regional Healthcare System ☐ Mary Black Health System

I GIVE DISTRICT 7 PERMISSION TO GIVE/USE FOR MY CHILD THE FOLLOWING:
(✓ YES or NO) Medication **will not** be given without written consent of a parent/guardian.

☐YES ☐ NO ACETAMINOPHEN/IBUPROFEN (store-brand Tylenol/Advil) for minor pain

☐YES ☐ NO DIPHENHYDRAMINE (store-brand Benadryl) for EMERGENCY allergic reactions

☐YES ☐ NO BENZOCAINE (store –brand for Orajel or Anbesol) for minor toothache

☐YES ☐ NO NON-NEOMYCIN ANTIBIOTIC OINTMENT for minor cuts or abrasions

☐YES ☐ NO CALAMINE/CALADRYL LOTION for minor skin irritations

☐YES ☐ NO CALCIUM ANTACID (store-brand Tums) for minor stomach discomfort

☐YES ☐ NO THROAT LOZENGE/THROAT SPRAY

MEDICAL HISTORY

Please place a check mark by all conditions that apply to your child and explain.
(Please contact the school nurse within the first **5 days of school** if your child has a **chronic health condition**)

☐ **Diabetes**

☐ **Seizures** – Describe ____

☐ **Asthma** – Does your child need to use an inhaler at school? ☐ **Yes** ☐ **No**

☐ **Allergies** – (Medications, food, seasonal) Describe ____

Does your child need to keep an Epi-pen at school? ☐ **Yes** ☐ **No**

☐ **Emotional/Behavioral Disorders** – Describe ____

☐ **Sickle Cell** ____

☐ **Hearing/Vision Problems** – Describe ____

☐ **Other illnesses/conditions** ____

PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES ____

Will any of these medications need to be given at school? ☐ **Yes** ☐ **No** If yes, please list which ones _____________________________________

If yes, please contact the school nurse for permission forms. All medications must be brought to the school nurse by a parent in the original container.

Family Doctor ____ Dentist ____

I give Spartanburg School District Seven permission to share the above medical information with members of the school's administrative faculty and staffs that have a legitimate need to know and to contact my child's doctor to share and obtain additional information as needed.

Parent Signature ____Date____________________________________

Signature certifies you have read and understand this form.