

Last School Attended _____

CAROLINA SCHOOL FOR INQUIRY
Richland County School District One

CONFIDENTIAL HEALTH QUESTIONNAIRE FOR SCHOOL NURSE ONLY

STUDENT NAME _____ BIRTHDATE ____/____/____
MALE FEMALE RACE _____ GRADE _____ HOMEROOM TEACHER _____

ADDRESS _____
ZIP CODE _____ HOME PHONE _____

STUDENT LIVES WITH (CIRCLE ONE): MOTHER FATHER BOTH PARENTS OTHER _____

MOTHER/ LEGAL GUARDIAN'S NAME _____ EMPLOYER _____
WORK NUMBER _____ CELL PHONE _____ E-MAIL _____

FATHER/ LEGAL GUARDIAN'S NAME _____ EMPLOYER _____
WORK NUMBER _____ CELL PHONE _____ E-MAIL _____

STEP PARENT (living with child) NAME _____ PHONE # _____

LIST THE NAME(S) OF ANY SIBLINGS AT PRESENT SCHOOL: _____

HEALTH CARE PROVIDER/NURSE PRACTITIONER _____
TELEPHONE NUMBER _____ LAST PHYSICAL/VISIT _____

DENTAL CARE PROVIDER _____
TELEPHONE NUMBER _____ LAST VISIT _____ (RECOMMENDED CLEANING EVERY 6 MONTHS)

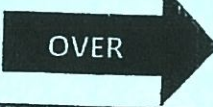
MEDICAID (CIRCLE ONE) Y / N _____ POLICY NUMBER _____

PREFERRED HOSPITAL _____

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

1. NAME _____ RELATIONSHIP TO STUDENT _____
PHONE NUMBER (WORK) _____ (HOME) _____ (CELL) _____
ADDRESS _____

2. NAME _____ RELATIONSHIP TO STUDENT _____
PHONE NUMBER (WORK) _____ (HOME) _____ (CELL) _____
ADDRESS _____

(PLEASE COMPLETE THE BACK OF THIS FORM)  OVER

For School Nurse Only: _____ Page 1
Reviewed By: _____ Date: _____ School Year: _____

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

Check	Condition	Explain
	ADD/ADHD	(CURRENT MEDICATION):
	ALLERGIES SEVERE REQUIRING AN EPI-PEN (Extra should be kept at school)	<input type="checkbox"/> Food: <input type="checkbox"/> Insects: <input type="checkbox"/> Seasonal:
	ANEMIA (LOW BLOOD)	
	ASTHMA (Inhaler should be available at school with completed medication forms on file)	Medication: Last Attack: ___/___/___
	BLADDER/URINARYCONDITION	
	BONE/ORTHOPEDIC CONDITION	
	DIABETES (SUGAR)	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: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT
	REACTIVE AIRWAY DISEASE	
	SICKLE CELL	Last Crisis: ___/___/___ Last Hospitalization: ___/___/___
	SICKLE CELL TRAIT ONLY	
	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

When possible, the parent/legal guardian should arrange for the student to receive medication before or after school hours.

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 signatures are required for prescription medication. Students that will self-medicate/carry his or her meds while at school (i.e. albuterol inhaler) should have a "parental release" and "self-medicating and/or self-monitoring" forms completed by the parent, health care provider and student.

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

PARENT/ LEGAL GUARDIAN'S SIGNATURE _____

DATE _____