BARROW COUNTY SCHOOL SYSTEM: STUDENT HEALTH SURVEY

Name: ____ Birth date:_____________

Grade: ___________ Homeroom Teacher: ___________________________ Biological Gender: ____ Male ____ Female

Insurance Information			**Doctor diagnosed conditions in the past 12 months:** Check all that apply for your child		
☐ Medicaid	☐ PeachCare	☐ No Insurance	☐ Asthma	☐ Head Injury or Concussion	☐ Fainting Spells
Other Insurance:			☐ Diabetes	☐ Seizures	☐ Reflux or Indigestion
			☐ Hypoglycemia	☐ Migraines	☐ Nose bleeds
Doctor / Pediatrician Name:			☐ Heart Condition	☐ Bladder/Kidney Problem	☐
Practice:		Phone:	Other:		
Specialty Doctor (If applicable):					
Practice:		Phone:	**Allergies:** Check all that apply for your child		☐ **NO allergies**
EYES: ☐ Wears glasses ☐ Wears contacts			☐ Insect stings	☐ Milk/Dairy	☐ Peanuts
EARS: ☐ Ear Infections ☐ Ear Tubes ☐ Hearing Problems			☐ Pollen	☐ Citrus	☐ Ants
Past Surgeries / Operations:			☐ Tree Nuts	☐ Other:	
			☐ **Epi-Pen is REQUIRED for above allergies. (Parent must provide medication.)**		
			☐ **Benadryl may be given for allergic relations if needed. (Parent must provide.)**		

**See your child's school handbook and/or the district website www.barrow.k12.ga.us about MEDICATIONS TO BE ADMINISTERED AT SCHOOL and other information.*

Medical Condition(s) or Problem(s):

If you see these symptoms:	Follow these actions:	Possible Triggers:	Medications, Dosage, Amount:

I verify that the above student information is correct to the best of my knowledge. I give permission for school health personnel to consult with my child's physician and for the nurse to communicate with school personnel regarding health-related issues, if needed.

If I cannot be reached in the event of an accident, illness, or emergency, I authorize the school to provide the necessary care to my child, which may include contacting emergency medical services and transportation to _______________________ Hospital (preferred hospital) or to the nearest local hospital, if necessary. Information on this form may be given to the hospital/medical staff to provide treatment needed for my child.

My child's school and the Barrow County School System will not be held responsible for adverse effects, injury, or financial obligations for such actions.

________________________________ ________________________________ ________________

Parent / Guardian Signature | Written Name | Date