BARROW COUNTY STUDENT HEALTH SURVEY

*** STUDENTS NEED TO BE FREE OF FEVER, VOMITING, AND/OR DIARRHEA FOR 24 HOURS BEFORE RETURNING TO SCHOOL. ***

Name:_____ **Grade:**_____ **Homebase Teacher:**_____

Birth date: _____ □Male □Female

Insurance Information: □ Medicaid -- □ PeachCare
□ Other Insurance:_____ □ ***NO Insurance***

Doctor / Pediatrician:_____
Phone #_____ Fax #:_____
Specialty Doctor (if applicable): _____
Phone #_____ Fax #:_____

EYES: □ Wears Glasses □ Wears Contacts
EARS: □ Recurrent Ear Infections □ Ear Tubes□ Hearing Problems

PAST SURGERIES / OPERATIONS:_____
_____

GENERAL HEALTH (Please √ as it applies to your child.)

□ Asthma □ Head Injury/Concussion □ Fainting Spells
□ Diabetes □ Seizures □ Reflux or Indigestion
□ Hypoglycemia □ Migraines □ Nose bleeds
□ Heart Condition □ Bladder/Kidney Problems
□ Other health problems not listed above:_____
_____

ALLERGIES: (Please √ as it applies to your child.) **[□ NO ALLERGIES]**

□ Insect Stings □ Peanuts □ Pollen □ Citrus
□ Ants □ Tree Nuts □ Milk/Dairy
□ Other:_____
□ **Epi-Pen IS REQUIRED for above allergies.** *(Parent must provide medication.*)
□ **Benadryl may be given for allergic reactions if needed.** *(Parent must provide)*

MEDICAL CONDITION(S) OR PROBLEM(S):	**Current Medications:**

If You See These Symptoms	***Follow These Actions***	***Possible Triggers That Cause Symptoms***	***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 & 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 absolutely 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 Co. School System will not be held responsible for adverse effects, injury or financial obligations for such actions.

_____ _____
Parent / Guardian Signature Date

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