DEKALB COUNTY SCHOOL DISTRICT
STUDENT HEALTH INFORMATION
School Year (2024 to 2025)

Student's Name____

Male or Female (please circle one) **Birth Date**: ___________ **Grade:** ____________

School:____ **Date**__________________

Please check any of the following that applies to the student: *Please provide documentation from your healthcare provider to confirm each diagnosis/symptom checked.

________**ADD**
________**ADHD**
________**Allergies; Specific type**________
Is EpiPen required? Yes ___ No___
________**Asthma**
________**Reactive Airway**
________**Frequent Bronchitis**
________**Chemotherapy / Immunosuppression**
________**Cystic Fibrosis**
________**Depression**
________**Diabetes: Type 1___ Type 2____**
________**Eating Disorder**
________**Underweight**
________**Overweight**
________**Head Injuries**
________**Hearing Loss**
________**Heart Disease**
________**Hemophilia**
________**Hepatitis**

______**Hypertension**
______**Injury, Major**
______**Kidney Disease**
______**Leukemia**
______**Nosebleeds (frequent)**
______**Organ Transplant**
(Please circle) Liver /Heart /Kidney
______**Orthopedic Problems**
______**Migraine Headaches**
______**Muscular Dystrophy**
______**Pityriasis Rosea**
______**Pneumonia**
______**Psoriasis**
______**Rheumatic Fever**
______**Seizure Disorder**
______**Sickle Cell Anemia / Trait**
______**TB**
______**Vision Loss**
______**Other**________________________________

If this student has any of the above, did he/she receive medical care? Yes____ No____

Is the student under medical treatment now? Yes___ No_____

If yes, what kind of medical treatment? ________________________________

Is the student on any kind of medication(s)? Yes____ No______

If yes, please list medication(s) ____

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NOTE: Please see the school health personnel for a Physician Request for Administration of Medication.
A physician/health care provider MUST sign a form for EACH medication to be taken in school.

Parent /Guardian Signature **(Phone Number)**

THIS INFORMATION IS CONFIDENTIAL. PLEASE RETURN FORM TO CLINIC AT YOUR SCHOOL.

***Please turn over and complete the form**

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EMERGENCY CONTACT INFORMATION

Father/Guardian ________________________________**Phone** (H) _____________ (C) ____________
Print Name
Phone (W) _____________

Mother/Guardian _______________________________**Phone** (H) _____________ (C) ____________
Print Name
Phone (W) _____________

If parents cannot be reached, list two nearby persons who will assume care of your child.

Name _________________________________ **Relationship** __________________ **Phone** __________________

Name _________________________________ **Relationship** __________________ **Phone** __________________

Child's Healthcare Provider ____**Phone** __________________

I give permission to contact my child's healthcare provider for further medical information. Yes ____ No _____

I also understand that in the event of an emergency, and I cannot be reached, that the school will have my child transported to the hospital via the EMS/911 service to receive appropriate treatment.

Parent Signature: _______________________________________ **Date:** ______________________________

Revised 6/30/22