****Note: This form must be completed****
Each School Year for Each Student.

Student Health Information
School Health Services
Garrett County Board of Education

Grade _____
Bus# _____

Student's Legal Name _____ Date of Birth ____/____/____
Last First M.I.

Please list only parent(s)/guardian(s) with whom the child resides.

1) Parent/Guardian _____ Relationship _____
Last First M.I.

2) Parent/Guardian _____ Relationship _____
Last First M.I.

Home Address _____

Home Phone # _____ Cell Phone # _____ Beeper # _____

Place of Employment: Father/Guardian _____ Phone # _____
Place of Employment: Mother/Guardian _____ Phone # _____

	Name	**Phone #**
Physician:		
Optometrist:		
Dentist:		
Orthodontist:		
Specialist:		

In the event that I am unable to be contacted, the following people are allowed to pick up my child from school:

Name	Address	Phone	Relationship

Permission is hereby granted for my child to be transported to whichever hospital is available for emergency care.

Preferred Hospital: _____

Parent/Guardian Signature 1) _____

2) _____

Other School Age Sibling(s): Name: _____ Grade: ____ School: _____
Name: _____ Grade: ____ School: _____
Name: _____ Grade: ____ School: _____

PLEASE TURN OVER AND COMPLETE.

Student's Name _____

Please check all boxes that apply to your child's health and give a brief description of the problems.
(symptoms, treatments, etc.)

☐ **ADD/ADHD**
___ Medication, Name: _____ Dose: _____ Time: _____ To be given in school? Yes No
_____ Dose: _____ Time: _____ To be given in school? Yes No

☐ **Allergies** _____
___ Medication, List: _____
Symptoms _____
___ Seasonal, List: _____
Symptoms _____
___ Food, List: _____
Symptoms _____

☐ **Asthma** (triggers, symptoms, frequency, what the school needs to do, etc.) _____
_____
☐ Medication, Name: _____ To be given in school? Yes No
_____ To be given in school? Yes No

☐ **Bee Sting**, Type of Reaction ___ Local (swelling and redness at site of sting, local pain)
___ Reaction (large amount of swelling, etc.) Requires use of Benedryl
___ Allergy - Requires use of an "Epi-Pen"
Describe symptoms specific to your child: _____
_____

☐ **Bowel/Bladder Problems**, Describe: _____
_____

☐ **Clotting Disorder**, Describe: _____
_____

☐ **Diabetes**, Describe Symptoms of LBS/HBS: _____
_____
☐ Insulin Dependent To be given in school? Yes No Describe: _____
Coverage? Yes No
_____
☐ Non Insulin Dependent, Describe (medications, diet, etc.) _____
_____

☐ **Heart Condition**, Describe: (medications, limitations, symptoms) _____
_____

☐ **Low Blood Sugar**, Describe: (symptoms, snack needed?) _____
_____

☐ **Orthopedic Problems**, Describe: (assistive devices, etc.) _____
_____

☐ **Seizure Disorders**, Describe: (type, frequency and duration, what does the school need to do? _____
_____
_____

☐ **Severe Illness/Injury**, Describe: (hospitalized? Etc.) _____

☐ **Other**, Describe: _____
_____

Information from this document will be shared with faculty and staff on a need-to-know basis to ensure the safety of your child.

No medication will be provided by the school. All medication must be provided by the parent/guardian. Medication will not be given without a completed Medication Form. Medication may not be carried by the student. If you child uses an inhaler, insulin or Epi-Pen, the parent/guardian and the child's physician must fill out the appropriate section of the Medication Form in order to be permitted to carry these medications. This is in accordance with Garrett County Board of Education's Medication Policy and adherence to a Drug-Free School Zone. Violation of this Policy could result in a suspension.