Dear Parent/Guardian,

I am sending this letter to gather information about students who have health needs. Please fill out the form below “Request for Health Information”, whether or not your student has medical needs that could affect learning or might require emergency care during the school day.

Chronic Health Conditions

- Please complete the form below annually.
- If your child has a life-threatening condition/allergy, please notify the school nurse and any other staff members who will be in contact with your child (including the cafeteria/bus driver/coach/extracurricular activities).
- Contact the school nurse if you need to schedule a conference to discuss details regarding the development of a health care plan for your child.
- Provide necessary updates that occur during the school year, either with contact numbers or your child’s health condition.

Medication Administration

- Medication must be sent in the original container if it is an over-the-counter medicine or a prescription bottle if it is a prescription medicine.
- Please check expiration dates. School personnel are not allowed to give expired medications.
- The school does not provide any medications, including ointments, creams, pain relievers, eye drops, etc. Any medication given at school must be provided by the parent/guardian.
- A medication consent form is required for any medication given at school.
- A doctor’s signature is required for any medication given daily, or on an “as needed” basis for longer than ten days. This includes ALL controlled substances, regardless of the length of time to be given, as well as inhalers, epi-pens, and insulin.
- Faxed consents from parents and/or doctors are acceptable.
- The entire UCPS medication policy may be viewed online at www.ucps.k12.nc.us.

If you have questions or concerns, please contact the school. I would be happy to speak with you.

Sincerely,

School Nurse

Request for Health Information
Must be completed annually

School ____ Date ____
Student's Name ____ Date of Birth ____
Teacher ____ Grade ____
Parent/Guardian (names) ____
Home Phone _________________________ Mom's work______________________ Mom's cell ______________________________
Dad's work ________________________ Dad's cell ______________________________
Emergency Contact Person ___________________________________ Daytime Phone ______________________________
Drug Allergy(s) _____ None Known _____ Yes (list) ____
Treating Physician ____ Office Phone ______________________________
_____ **MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS. (You may stop here if there are no known medical concerns. Please sign at the bottom and return.)**

Asthma Triggers: _____environmental _____seasonal _____exercise induced
Inhaler at school- _____ upper respiratory infection _____ others ______________________________
MD order required. Inhaler location: _____ carried by student **(requires self carry form)**
_____ classroom _____Health Room

Diabetes _____ Type 1 _____ Type II Diagnosis Date: _______ Insulin by: _____ Pump _____Injections
Desire Diabetes Care Plan: _____yes _____no, independent with all care. **Please call for Nurse Conference – Notify your school nurse and principal immediately if newly diagnosed.**

Food Allergy** _____ Peanuts _____ Tree Nuts _____Milk _____ other/s ______________________________
Date/Type of Last Reaction ____
Student Needs for Class/School ____
Diet Order signed by MD required (diet form may be obtained in the front office)

Severe Sting Allergy**
Date and Type/Description of Last Reaction
____
____

****Notify your school nurse and principal immediately if anaphylaxis may occur****

Epilepsy Type(s) of Seizure(s): ____
_____ controlled with medication _____ on medication, continues to have seizures
_____ Diastat needed at school _____ no medication needed at school
Date and Type/description of last seizure ____

Other conditions/or specify pertinent data to help us better serve your child: ______________________________
____

Does your child take routine medication(s)? _____ yes _____ no List Meds: ______________________________

Does your child need medication(s) at school? _____ yes _____ no List Meds: ______________________________

If your child needs medication at school, a medication consent form is needed by the school.
****Medication cannot be given at the school until appropriate consents have been received.****
****UCPS does not provide medications for students.****

I give permission to the School Staff/School Nurse to share information regarding my child's medical condition(s) with my physician or emergency personnel:
Date: ________________ Parent/Guardian Signature ____

This form will serve as an Individual Health Plan and may be distributed to pertinent school employees. A more detailed Individual Health Plan will be developed by the nurse in order of medical priority, or per your request. Please let your school nurse know if your child participates in extracurricular school activities.