Bedford County Schools Student Health Registration Form

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning.

Student's Name _____
First *Middle* *Last*

School: _____ **Grade:** _____ **Homeroom:** _____ **Sex:** _____ **Date of Birth:** _____

Bus rider Yes ☐ No ☐ AM Bus # _____ PM Bus # _____

MEDICAL Does your child have a doctor or nurse practitioner? Yes ☐ No ☐ **Name of Doctor** _____
In the past 12 months, did you have problems obtaining medical care for your child? Yes ☐ No ☐

DENTAL Does your child have a dentist? Yes ☐ No ☐
Did your child receive a dental exam in the last 12 months? Yes ☐ No ☐ Don't know ☐

PSYCHOLOGICAL Does your child receive outpatient counseling services? Yes ☐ No ☐

MEDICAL HISTORY *Have you ever been told by a physician or other health care professional that your child has:*

☐ Asthma
☐ Seizure disorder
☐ Bleeding disorder
☐ ADD/ADHD
☐ Diabetes
☐ Heart condition
☐ Bone/muscle disease
☐ Skin condition
☐ Mental health condition (i.e., depression, anxiety, eating disorder

Describe: _____

Does your child experience any of the following?

☐ Frequent earaches
☐ Physical disability
☐ Frequent headaches
☐ Fainting spells

Other _____
Do any of the above condition(s) limit/effect your child at school? Yes ☐ No ☐ Describe _____

LIFE-THREATENING CONDITIONS Does your child have a life-threatening health condition?
Yes* ☐ No ☐ Describe: _____

***If yes, a meeting with the school nurse is required. Medication or treatment orders and a health care plan should be in place prior to starting school.**

ASTHMA Is inhaler used? Yes* ☐ No ☐ (*If yes, parent must provide inhaler.)

ALLERGIES: ☐ Food** _____ ☐ Latex ☐ Bees/Wasps
Other: _____ Please describe the allergic reaction and the treatment: _____
Is an Epi-pen prescribed? Yes* ☐ No ☐ (*If yes, parent must provide Epi-pen)

**If your child is allergic to food, an additional form must be completed for school prepared meals.

***If your child needs to take medication at school, please contact the office for the necessary authorization form. This form must be completed prior to the administration of any medication at school. Your child may carry an Epi-pen or inhaler if medically authorized and developmentally appropriate after informing school personnel and completing the necessary medical forms.**

Date of last tetanus shot: _____

HEARING/VISION Does your child have a hearing problem? Yes ☐ No ☐ Does your child wear hearing aids? Yes ☐ No ☐
Does your child wear ☐glasses? ☐ contacts? To be worn at all times ☐ To be worn as needed ☐

Health History Informed Consent and Medical Release
I understand that the information given above will be shared with appropriate school staff on a need-to-know basis to provide for the health and safety of my child and to foster academic success. In the event that neither I nor another emergency contact can be reached during a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

_____
Parent/Guardian Signature Printed Name Date

_____
Telephone Number(s) (with area code) and Email Address