Please complete and return to your School Nurse

HEALTH HISTORY

Student: _____DOB: _____

Teacher: _____Grade: _____

If the student has **NO HEALTH CONCERNS FOR SCHOOL AT THIS TIME**, please sign here and return to School Nurse.

Parent Signature: _____ Phone Number_____

Date: _____

*** IT IS THE PARENT'S RESPONSIBILITY TO TURN IN PHYSICIAN ORDERS FOR ANY MEDICATIONS, PROCEDURES, OR SPECIAL DIETS NEEDED AT SCHOOL. ***

- FORMS FOR MEDICATIONS, PROCEDURES, AND SPECIAL DIETS CAN BE FOUND ON THE CABELL COUNTY SCHOOLS WEBSITE AT www.cabellschools.com. To locate forms, go to the "Families" tab, then the Student Support Services tab. Along the left-hand side of the screen, click Student Health. All forms are on the right-hand side of the page. You can also contact your school nurse for a blank copy of the forms.
- ALL MEDICATIONS, INCLUDING **OVER-THE-COUNTER (OTC) MEDICATIONS** MUST BE PRESCRIBED BY YOUR CHILD'S DOCTOR ON THE SCHOOL'S APPROVED MEDICATION ADMINISTRATION FORM, SIGNED BY A PARENT OR GUARDIAN, AND RETURNED TO THE SCHOOL BEFORE THE MEDICATION CAN BE GIVEN AT SCHOOL. High school students may be approved to carry a 3-day supply of OTC medications in a labeled bottle with parent/guardian authorization, unless restricted by administration.
- STUDENTS ARE NOT ALLOWED TO SELF-CARRY MEDICATIONS AT SCHOOL UNLESS ORDERED BY A DOCTOR AND REVIEWED BY THE SCHOOL NURSE.
- STUDENTS CANNOT CARRY THE MEDICATION TO BRING INTO THE SCHOOL NURSE. The medication is to be brought to school by the parent or other responsible adult in a properly labeled (pharmacy prescription label with child's name and orders) container from the pharmacist or manufacturer (original bottle if OTC medication).
- The student is responsible for coming to the office or designated person to take their medication.
- Parent/guardian is responsible for picking up medications at the end of the school year. If the medication is not picked up, it will be discarded.

Condition: _____

Needs at School: _____

Parent signature: _____ Phone Number: _____

Date: _____

School Nurse use only:
Medication received: Y/N Date:
Forms sent home: Y/N Date:
Forms received: Y/N Date:
Condition: Y/N Date:

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