

**CHEROKEE COUNTY SCHOOL DISTRICT
STUDENT HEALTH NEEDS IDENTIFICATION FORM**

**THIS FORM IS TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN AND
RETURNED TO THE SCHOOL NURSE.**

STUDENT'S NAME _____ D.O.B. _____
 SCHOOL _____ GRADE _____
 HOMEROOM TEACHER _____ TEAM _____

SIBLING(S) ENROLLED IN CCSD:

Name _____	Grade _____	School _____
Name _____	Grade _____	School _____
Name _____	Grade _____	School _____
Name _____	Grade _____	School _____

PARENT/LEGAL GUARDIAN _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

PHYSICIAN _____ PHYSICIAN'S PHONE No. _____

Is your child allergic to any medications? YES No If yes, please list _____

MEDICAL HISTORY: Please check below if your child has now or has had in the past:

	NOW	PAST		NOW	PAST
Asthma treated with daily medication			Nosebleeds		
Diabetes			Respiratory problems		
Seizures/Epilepsy			Cancer		
Heart Problems			Kidney problems		
Headaches			Blood disorders		
Skin diseases			Other:		
*Allergies (see below)			Other:		

Please describe other medical problems: _____

Does your child have any physical, hearing or visual disability? Yes No

If yes, please describe: _____

Does your child have a medical procedure that must be performed during the school day? Yes No

If yes, please list: _____

*Does your child have allergies to food or insects? Yes No

If yes, please list: _____

*Has your child experienced an anaphylactic reaction in the past (including, but not limited to, difficulty breathing or shock)? Yes No

*Has an emergency epinephrine injector been used on your child due to an anaphylactic reaction? Yes No

If yes, please describe the circumstances: _____

List any medication(s) your child is taking that the school nurse and/or staff should be aware of:

The school cannot administer any medication until a medication authorization form has been completed for each medication. Medication must be provided by a parent/legal guardian.

Parent/Legal Guardian Signature

Date