Campbell County School District #1
Nursing Services

School Nurses Campbell County

CONFIDENTIAL STUDENT HEALTH FORM

LAST:	FIRST:	MI:	Date of Birth:	Gender ☐ M ☐ F

CURRENT HEALTH CONDITIONS

*Please check the following health conditions which have been **DIAGNOSED by a doctor** **(or other health care provider)***

☐**The student does not have any health concerns.**

☐ Allergies (not severe): _____ ☐ Severe Allergies* (epinephrine needed): _____

☐ ADD/ADHD	☐ Emotional/Behavioral	☐ Heart/Blood	☐ Stomach/Bowel
☐ Asthma*	☐ Glasses/Contacts/Vision	☐ Muscles/Bones/Joints	☐ Toileting Concerns
☐ Bladder/Kidney	☐ Head Injury/Concussion	☐ Seizure Disorder* (active)	☐ Other: _____
☐ Diabetes*	☐ Hearing	☐ Special Dietary Needs	*Please consult with school nurse

Please describe any of the above conditions you have checked (*use other side if necessary*): _____

_____

_____

CURRENT MEDICATIONS

*List **ALL** medications including the name of medication, dose, and schedule (use other side if necessary)*

☐**The student does not take any medications.**

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

OTHER HEALTH INFORMATION

Prior or current IEP or 504? If yes, briefly describe: _____

_____

Activity restriction and/or special medical equipment required in school? (e.g. oxygen, wheelchair, catheter):

_____

Injuries	Date	Surgeries	Date	Hospitalizations	Date

Health Insurance Portability and Accountability Act 1996 (HIPAA) and the Family Education and Right to Privacy Act (FERPA): I authorize the sharing of my child's health information identified on this form to provide appropriate school services. I understand I am responsible for providing the school with any medication(s), treatment supplies, and/or equipment that is required during the school day and further agree to complete all requested health care plans and notify school nurse of health updates or medications changes. This authorization is effective immediately and until revoked in writing by parent/guardian.

School Nurse WyIR Access Agreement (www.health.wyo.gov)**:** To ensure the Wyoming Department of Health is aligning with the HIPAA Omnibus Rule, Wyoming School Nurses must obtain parent/guardian agreement before accessing a student's immunization record within the Wyoming Immunization Registry (WyIR). No student record shall be accessed in the WyIR by a School Nurse without parent/guardian agreement. Thus by signing this form, I am giving the School Nurse representing **Campbell County School District** permission to access this student's immunization record in the WyIR.

PARENT/GUARDIAN NAME (PLEASE PRINT): _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

REVISED 5/15/2020

COMPLETE BACK PAGE

CURRENT HEALTH CONDITIONS CONTINUED (IF NECESSARY)

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS CONTINUED (IF NECESSARY)

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

Medication: _____ Dose: _____ Schedule: _____ Will need at school: YES NO

OTHER HEALTH INFORMATION CONTINUED (IF NECESSARY)

_____

_____

_____

_____

_____

_____

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____