FREMONT COUNTY SCHOOL DISTRICT NO. 2
Every Day Counts: Educate, Engage, Empower

Confidential Health Information

Anna Hinkle L.P.N District Nurse 455-5511 ahinkle@fremont2.org

Student Information

Student Name _____ Date of Birth _____Age _____ Grade _____

Male _____ Female_____ Medical Provider _____ Medical Provider Phone _____

Current Health Conditions

Please check the following health conditions ***DIAGNOSED*** by your healthcare provider.

☐ **The student does not have any medical concerns**

☐ Diabetes *	☐ Severe Head Injury	☐ Skin	☐ Vision
☐ Active Seizure Disorder *	☐ Migraines/Chronic Headaches	☐ Bladder/Kidney	☐ Dental
☐ Severe Allergies *	☐ Heart/Blood Disorder	☐ Stomach/Bowels	☐ Hearing
☐ Asthma *	☐ Muscles/Bones/Joints	☐ Emotional/Behavioral	☐ Other
*** Requires completed CARE PLAN (Obtain from the nurse)**			

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

_____

_____

_____

Current Medications

List ALL medications including the name, dose, frequency, and name of the prescriber.

☐ **The student does not require medication at school**

If the student requires prescription medications at school, the health care provider and parent **MUST** complete and submit the FCSD #2 Request For Administration of Medication form. The form can be obtained from fremont2.org or the nurse. Medications:

_____

_____

_____

Over-the-counter medications provided at FCSD #2

Please check all that you will allow your child to have at school.

- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Cough drops
- ☐ Benadryl (for allergic reaction)
- ☐ Topical ointments such as Bacitracin and hydrocortisone 1%

School nurse Wyoming Immunization Registry (WyIR access agreement): Please check one.

- ☐ I permit the school nurse to access my child's immunization records on the WyIR.
- ☐ I **do not** permit the school nurse to access my child's immunization records on the WyIR

Signature of parent/guardian: _____ Date: _____

CONTINUED

Health Services at FCSD #2
Parent/guardian permission is required for participation in health services. Failure to return this form or provide permission online will result in your student **NOT** being able to participate in this program.
**This means your child will not receive any health services.

Health Service Categories (examples include, but are not limited to):

- Illness Assessment: vital signs, review of symptoms, physical assessment, chronic disease care, and communicable disease assessment.
- Injury Assessment: vital signs, review of symptoms, physical assessment, first aid
- Wellness Assessment: lice assessment, oral health, hygiene (feminine and other), incontinence, spills, clothing, nutrition, repairing broken items, special education evaluations.
- Mental Health Assessment: panic attacks, self-harm, bullying, vital signs, physical assessment, mental health assessment.
    - Nurses are often the first to see and assess. Our practice would be to get a student to a school mental health counselor as soon as possible.

Do you permit your student to participate in ALL health services?

- ☐ YES
- ☐ NO

If answering no, do you permit your student to participate in **ANY** health services?
Please indicate yes or no to each category.

Illness Assessment

- ☐ YES
- ☐ NO

Injury Assessment

- ☐ YES
- ☐ NO

Wellness Assessment

- ☐ YES
- ☐ NO

Mental Health Assessment

- ☐ YES
- ☐ NO

Health Screenings
Vision and hearing screenings are completed on students in the following grades and classifications annually:
Vision: Pre-K, K, 1, 3, 5, 8 and 10
Hearing: Pre-K, K, 1, 2, 3, 5, and 8
All special education and new students in the district

IF YOU DO NOT WANT YOUR CHILD TO PARTICIPATE IN VISION AND HEARING SCREENINGS, YOU MUST CONTACT THE SCHOOL NURSE IN WRITING EACH SCHOOL YEAR.

I have been informed of the **opt-in** updates to Health Services provided and the **opt-out** requirements for student Health Screenings. I understand it is my sole responsibility as a parent/guardian to opt-in for the school nurse or designee to provide health services to my child.

Signature of parent/guardian: _____ Date: _____