



Confidential Health Information

Frederick County Public Schools
191 South East Street
Frederick, Maryland 21701

Form #069.1E
March 2026

*In case of emergency, school staff will contact 911.
Every attempt will be made to contact a parent, guardian, or designated emergency contact.*

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Grade
School Name:					
Does the student have health insurance? <input type="checkbox"/> Private <input type="checkbox"/> Medical Assistance <input type="checkbox"/> No Insurance			Does the student have dental insurance? <input type="checkbox"/> Y <input type="checkbox"/> N		

CURRENT HEALTH CONCERNS

Please check the following health concerns that may impact the student's educational day. This information may be shared with FCPS staff as appropriate.

The student does not have any medical concerns

- | | |
|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Diabetes Type 1 (Insulin Dependent) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes Type 2 (Non-Insulin Dependent) | <input type="checkbox"/> Other Mental Health Conditions _____ |
| <input type="checkbox"/> Allergies (choose all that apply) | <input type="checkbox"/> Behavioral Diagnosis/Concerns _____ |
| <input type="checkbox"/> Foods _____ | <input type="checkbox"/> Intellectual Disability _____ |
| <input type="checkbox"/> Bee Sting/Insect Bite _____ | <input type="checkbox"/> Hearing Concerns <input type="checkbox"/> Hearing Aid(s) |
| <input type="checkbox"/> Medicines _____ | <input type="checkbox"/> Vision Concerns <input type="checkbox"/> Eyeglasses/Contact Lenses |
| <input type="checkbox"/> Pesticides/Chemicals* _____ | <input type="checkbox"/> Heart Concerns _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Life-Threatening Allergy/Anaphylaxis | <input type="checkbox"/> Physical Disability _____ |
| <input type="checkbox"/> Asthma:
Has the student experienced an asthma episode in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other Blood Disorder _____ | |

This information is a change in health condition from the last school year

FCPS uses the Integrated Pest Management programs to identify and control pest problems in schools. **Elementary schools must notify staff and parents/guardians of all students 24 hours before pesticides are to be applied inside the school building or on the grounds. **Middle and high schools** must notify only those parents, guardians or staff who have filed a written request for notification; forms are available at each school and must be updated every school year. See the FCPS Calendar Handbook for details, or contact your child's school.*

MEDICATIONS: List all medications and dosages your child receives on a routine basis

Medications are not required at school

Medications: _____
*If the student requires over-the-counter or prescription medications or treatments at school, the health care provider and parent **must** complete and submit the appropriate authorization form(s). Obtain forms from the health staff at your child's school or at <http://www.fcps.org/> (click on Forms).*

- I give permission for health room staff to apply or provide: calamine lotion petroleum jelly, Aveeno lotion, or Eucerin Cream to my child as needed and appropriate for minor skin irritation.

I hereby give authorization and consent to the school, in the event that I cannot be contacted, to obtain emergency medical care and necessary emergency transportation to a healthcare facility. I understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with FCPS/Frederick County Health Department staff and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.

Parent/Guardian name (please print): _____ Primary Contact Ph# _____

Signature of Parent / Guardian: _____ **Date** _____