North Carolina Governor's School 2023
GENERAL HEALTH INFORMATION FORM (3 pages)
Completed by Parents/Guardian

- **Parents/Legal Guardians. Complete both pages and submit.**
- **Print, fill out with pen legibly, scan and then upload to the Registration Packet (or) If you have Adobe, you may electronically complete and upload the signed form to the Registration Packet.**

Student Legal Name _____ Preferred Name _____

Official Sex _____ Gender_____ Date of Birth _____Student's Cell # _____

Parent/Legal Guardian Names _____

Email Addresses_____

Parent/Legal Guardian Phone # (1st option) _____ (2nd option) _____

Home Address _____

Street and Number City State Zip Code

In case of emergency, contact (other than parents):

Name _____ Relationship _____

Best Phone # _____ Best Email Address _____

The information below is necessary for the Governor's School (GS) to better plan for and make decisions regarding the wellbeing of your child should needs arise during the GS session. All information will be kept confidential by medical and administrative staff throughout your child's GS experience. Full disclosure of any medical issues will permit the most appropriate and effective response to their needs during their stay and in the event of a medical emergency.

Answer questions; explain "Yes" answers below. Circle questions you cannot answer.

		Yes	No
1.	Has a doctor ever denied or restricted your child's participation in sports or any other activity?	☐	☐
2.	Does your child have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Does your child have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
4.	Has your child ever had (check all that apply)? ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
5.	Has a doctor ever ordered a test for your child's heart? (for example: echocardiogram)	☐	☐
6.	Was your child born without or is he/she missing a kidney, an eye, or any other organ?	☐	☐
7.	Does your child have any rashes, pressure sores, or other skin problems?	☐	☐
8.	Has your child ever had a seizure?	☐	☐
9.	Does your child have sickle cell trait or sickle cell disease?	☐	☐
10.	Has your child had any vision problems?	☐	☐
11.	Does your child wear glasses, contact lenses or hearing aids?	☐	☐
12.	Do you or your child have any concerns that you would like to discuss with a doctor?	☐	☐
13.	Does your child have or is your child being treated for a mental health needs or diagnosis?	☐	☐

Explain "Yes" answers here: _____

_____

_____

Please list any prescription or nonprescription (over-the-counter) medications your child is currently taking:

Name of drug	Dosage	Dosage instructions	Diagnosis/reason for medication	How long student has been taking

Check the box if your child has a history of any of the conditions below. Give approximate dates and explanations where appropriate.

		Yes	Date(s)
1.	Frequent colds	☐	
2.	Kidney trouble	☐	
3.	Chickenpox	☐	
4.	Sinusitis	☐	
5.	Headaches	☐	
6.	Abscessed ears	☐	
7.	Convulsions	☐	
8.	Fainting	☐	
9.	Rheumatic fever	☐	
10.	Constipation	☐	
11.	Frequent sore throats	☐	
12.	Bronchitis	☐	
13.	Athlete's foot	☐	
14.	Chronic depression	☐	
15.	Eating disorders	☐	
16.	Sleepwalking	☐	
17.	Upset stomach	☐	
18.	Serious Ivy, Oak, or Sumac Poisoning	☐	
19.	Tuberculosis	☐	
20.	Mononucleosis (mono)	☐	

		Yes	Date(s)	Explanation
21	Operations or serious injuries	☐		
22.	Hospital admission or outpatient treatment	☐		
23.	Physical disabilities that require special care	☐		
24.	Mental/emotional health problems/needs	☐		
25.	Specific activities to be discouraged	☐		

Has your child been exposed to any communicable diseases during the last month, including COVID-19?
No or Yes/Explain _____

Please also notify the Governor's School staff during Opening Day if this changes before arrival.

IN CASE OF EMERGENCY: I understand every effort will be made to contact parents or guardians of students. In the event I cannot be reached, I hereby give permission to the physician selected by the school to consult with my child's medical or psychological professional listed below, to hospitalize and/or secure proper treatment for, and to order injections, anesthesia or surgery for my child, as named above. The medical and/or psychological professionals to contact are:

Doctor's Name _____

Medical Specialty _____ Telephone _____

Doctor's Name _____

Medical Specialty _____ Telephone _____

PRESCRIPTION MEDICATIONS: I understand every effort will be made to contact parents or guardians of students with all medication issues. In the event my student loses or otherwise misplaces their prescription medications while at Governor's School, the GS staff will make every effort to retrieve a new prescription for the student at a local pharmacy. I may be asked to contact my child's medical or psychological professional in order to obtain needed medications. I will coordinate with GS staff to find a local pharmacy for the prescription to be sent and filled. I further understand and assume responsibility for the costs of any prescription medications regardless of insurance coverage.

Please read the following statements and sign below:

- I hereby state that, to the best of my knowledge, the information I have provided on this form is complete and accurate. I hereby give my permission to the Governor's School to release my child's medical record to a physician, hospital, pharmacy, or other medical professional involved in providing my child with emergency treatment or medical care.
- I understand that Governor's School will provide the medical service provider with a copy of my child's insurance card (if submitted via the Registration Packet). I assume responsibility for the costs of any medical services provided regardless of insurance coverage.

For GS West students only: The Winston-Salem State University (WSSU) Student Health Services will be providing basic care during the week. I hereby give my permission to the WSSU Institution to release my child's medical record to a physician, hospital, or other medical professional involved in providing my child with emergency treatment or medical care. I hereby authorize any medical treatment for my child that may be advised or recommended by the Student Health Services. WSSU will seek parental consent to treat a minor via phone.

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian Printed Name _____