Gray Stone Day School Request for Health Information and Services

Last Name	First	Middle	Grade

This information is confidential & will only be shared on a need-to-know basis to ensure the health & safety of the student. PLEASE CHECK THE CONDITION(S) YOUR CHILD HAS BELOW:

___Autism ___Cancer/Leukemia Date Diagnosed: _____ ___Cerebral Palsy ___Crohn's Disease/IBS ___Cystic Fibrosis ___Down's Syndrome	___Glasses/Contacts ___Hearing Aid/Loss ___Heart Conditions Type:_____ ___Hemophilia/Bleeding Disorder ___Migraine Headaches ___Neuromuscular Disease	___Orthopedic Disability ___Renal/Kidney Disease ___Juvenile Rheumatoid Arthritis ___Seasonal Allergies ___Sickle Cell Anemia ___Ulcers/Gastric Reflux ___Other:_____

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

Medication (OTC or prescription) cannot be given at school until healthcare provider & parent/guardian consent forms have been received. Medication needed at school: ____No ____Yes:_____	
Severe Allergies Notify your School Nurse **IMMEDIATELY** if anaphylaxis may occur.	Allergic to: ___Peanuts ___ Tree Nuts ___ Dairy ___ Eggs ___ Stings Other: _____ Has an Epi-Pen/Auvi-Q/Benadryl been prescribed? ___ No ___ Yes: _____ Date/Type of Last Reaction: _____
Asthma	Date of last asthma attack: _____ Rescue Inhaler needed at school: ___No ___Yes
Epilepsy/Seizures	Type of Seizure: ___Convulsive ___Non-Convulsive ___Absence ___Febrile Emergency Seizure medication needed at school: ___No ___Yes: _____
Diabetes	___Type I ___Type II Diagnosis Date: _____ ___Insulin Pump ___Injections
ADD/ADHD **Mental Health**	___ADD/ADHD ___Anxiety ___Depression ___Other:_____ Medication/Treatment: _____ Medication needed at school: ___No ___Yes: _____
Concussion	History of a concussion: ___No ___Yes Date: _____

It is the responsibility of the parent/guardian to 1. Notify the school nurse of any health condition or changes. 2. Notify the school when parent contact info changes. 3. Provide medications, supplies & written provider's orders when needed.

By signing below, I give consent for School Health Services to provide ANY health care service. This includes but is not limited to band aids, ice packs, temperature checks, blood pressure monitoring, etc. I understand I will be notified of illness or injury at the discretion of staff. I understand that my child's medical information will be shared with school officials and emergency personnel who have a legitimate medical/educational purpose for accessing such medical information. The school will call 911 as deemed necessary.

Parent/Guardian Signature: _____ Date: _____

*For additional information about School Health Services, please refer to our Gray Stone Day School website under General Info/Health Services.

Opt-IN/Opt-OUT for Consent for Student Support Services at Gray Stone Day School
2026-2027 School Year

North Carolina State Law requires annual written notification regarding school mental health services. This form offers you the opportunity to ***"Opt In"*** to **allow your student to receive supportive services** OR "***Opt Out***" to **deny your permission for supportive services** as delivered by the School Counselor at Gray Stone Day School.

Supportive Services include discussing age-appropriate topics such as:

- getting along with others
- staying safe
- coping skills
- learning to be a successful student
- being upset at school and needing to talk about something bothering them

School Counselors do not diagnose any conditions and do not provide any mental health treatment. Parents/Guardians will be contacted if additional resources or services may be beneficial. I understand that parent/legal guardian permission is required for **ongoing** supportive, individual and group interventions.

This form does not apply to **Academic Services** performed by the School Counselor, including but not limited to scheduling, attendance, academic grades, college planning, etc.

If you have any questions or concerns regarding this information, please contact **Roy Morgan, School Counselor at Gray Stone High School** or **Jan Poindexter-Cameron, School Counselor at Gray Stone Middle School.**

Please mark below if you wish to "***Opt IN***" and **allow your student to receive support services** or "***Opt OUT***" and **deny your permission for supportive services**:

☐ I agree and consent to supportive services for my child from School Counselors at Gray Stone Day School.

☐ I do not agree / do not consent to supportive services for my child from School Counselors at Gray Stone Day School.

Consent will be considered granted if no form is returned.

I reserve the right to change this decision at any time by contacting the school in writing.

This consent will become effective from the day it is received by the school and will remain in effect for the school year. Consents will not transfer from school to school. A new consent form will need to be completed each time your child changes schools.

Student Name: _____

Grade Level: _____

Parent Name: _____ ***Date:*** _____