HEALTH HISTORY/EMERGENCY CONTACT FORM 2021-2022

The following information about your child is requested in order for the School Health Nurse to provide the most appropriate school health services for your child. ***PLEASE COMPLETE AND RETURN TO THE SCHOOL HEALTH CLINIC.***

STUDENT'S NAME: ____GRADE: _____________
DATE OF BIRTH: ____________________ SEX: _______ HOMEROOM TEACHER: ____________________________________
PARENT/GUARDIAN NAME: ____ HOME PHONE: ________________________
Parent/Guardian Address: ____ WORK PHONE: ________________________
Parent's cell phone number(s) __________________________ ________________________________

EMERGENCY CONTACT if unable to reach parent/guardian: ____
RELATIONSHIP: _____________________________HOME PHONE : __________________ WORK PHONE: _____________________
Emergency contact's cell phone number(s) _______________________ _____________________________

STUDENT'S PHYSICIAN: ______________________________ PHYSICIAN PHONE NUMBER ________________________________

CHECK ANY THAT <u>CURRENTLY</u> APPLY TO YOUR CHILD	PLEASE DESCRIBE
1. ____ Eye or Vision problems	1. ________________________________
2. ____ Ear/Hearing problems	2. ________________________________
3. ____ Lung/Breathing problems, asthma, etc.	3. ________________________________
4. ____ Heart problems/surgery/blood pressure problem	4. ________________________________
5. ____ Kidney/bladder problems, surgery, etc.	5. ________________________________
6. ____ Bone, joint or muscle problems	6. ________________________________
7. ____ Neurological problems, seizures, etc.	7. ________________________________
8. ____ Spine or back problems, surgery, etc.	8. ________________________________
9. ____ History of emotional/mental health problems treatments or hospitalizations	9. ________________________________
10. ____ Alcohol/drug use/abuse or treatment	10. ________________________________
11. ____ Diabetes (Type I or Type II)	11. ________________________________
12. ____ Cancer	12. ________________________________
13. ____ ADD/ADHD	13. ________________________________
14. ____ Sickle Cell Disease or bleeding disorders	14. ________________________________
15. ____ Cystic Fibrosis	15. ________________________________
16. ___ Autism Spectrum Disorders	16. ________________________________
17. ___ Lupus	17. ________________________________

18. List **any chronic or long term condition**____
19. List any surgery, date and reason ____
20. List any hospitalization in the past five years____
21. List **any restrictions on activity/physical handicaps**____
____
22. List **all daily medication your child takes** ____
____
23. List all **allergies to medications**, food products or insect stings your child has ______________________________
Please specify those that are **severe** ____
Does your child have an Epi-Pen? _________________________Will you be providing one for the school? [ ] Yes [ ] No

MY CHILD (STUDENT'S FULL NAME): ______________________________ has my permission to take part in the School Health Services Program. I understand that my child will receive emergency care in the school, if needed and health services at school that *may* include:

* First aid for minor injuries, accidents or illnesses
* Vision, hearing, height-weight, dental and scoliosis screenings
* Assistance with administration of doctor ordered medications
* Health education on specific health topics and approaches to wellness
* Assistance with doctor ordered minor, complex or chronic health conditions or procedures
* Immunization status and health history reviews
* Age appropriate reproductive health counseling

I authorize the School District of Monroe County, Florida to release and exchange my child's confidential information to agencies of the State of Florida to determine Medicaid eligibility and if applicable to bill Medicaid for reimbursable Certified School Match services referenced on my child's individual education plan (IEP) and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will receive services referenced on his/her IEP whether or not I give consent.

I understand that in case of an accident or serious injury, I will be contacted. If I cannot be reached, I understand the contact the person/s listed on this form as emergency contacts, will be contacted.

PARENT/GUARDIAN SIGNATURE: ____ DATE: _____________