HEALTH HISTORY/EMERGENCY CONTACT FORM 2025-2026

This is required information that will be kept in *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 CURRENTLY 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
* Use of otoscopes (to look in ears), tongue depressors (to look at back of throat), tympanic thermometers (to take temperature by ear), or oral thermometers (to take temperature by mouth) to assess/screen for illness and refer as necessary
* Vision, hearing, height-weight, dental and scoliosis screenings
* Assistance with administration of doctor ordered medications
* Assistance with doctor ordered minor, complex, or chronic health conditions or procedures

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, first aid will be administered, and 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: _____

IF YOU DO NOT WANT YOUR CHILD TO BE SEEN IN THE CLINIC, PLEASE ATTACH A WRITTEN NOTICE TO THIS FORM