HEALTH HISTORY/EMERGENCY CONTACT FORM 2024-2025

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