Student Health History & Emergency Medical Treatment Consent Form

School Year _____

Student	**School**	**Grade/Teacher**
Address	**Birth Date**	**Gender**

Parent/Guardian/Emergency Contacts	**Relationship**	**☎ Phone**
Call 1st:		Home: Cell: Work:
Call 2nd:		Home: Cell: Work:
Call 3rd:		Home: Cell: Work:

Student's doctor/healthcare provider: _____ **Phone:** _____

Insurance Information: _____

(Include Group's Name, ID Number, Group Number, and Subscriber)

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	**Yes**	**No**	**Explanation if "Yes"**
Medication Allergies	☐	☐	**List:**
Food Allergies	☐	☐	**Food(s):** ☐ **peanut** ☐ **dairy** ☐**eggs** ☐**other** _____ **Rate the reaction:** ☐mild ☐moderate ☐ life-threatening **Does your child require an EpiPen?** ☐yes ☐no
Allergy to Bees Stings	☐	☐	**Rate the reaction:** ☐mild ☐moderate ☐ life-threatening **Does your child require an EpiPen?** ☐yes ☐no
Allergies (other)	☐	☐	**List:**
Asthma	☐	☐	**Rate the severity:** ☐mild ☐moderate ☐ life-threatening **Asthma medication taken at home:** **Medication required at school:**
Diabetes	☐	☐	☐**Type 1** (Insulin Dependent) ☐**Type 2** **Diabetes medication(s) taken at home:**
Seizure Disorder	☐	☐	**Type of Seizure:** **Medications:**_____
Neurological Disorder	☐	☐	**Specify:**
Heart Condition	☐	☐	**Specify:**
Blood Disorder	☐	☐	**Specify:** **Treatment:**
Cancer	☐	☐	**Specify:** **Treatment:**
Bowel/Bladder Issues	☐	☐	**Specify:**
Migraine Headaches	☐	☐	**Triggers:** **Treatment:**
Bone/Muscle Problems	☐	☐	**Specify:** **Activity Restrictions:**
ADD/ADHD	☐	☐	**Medication for ADD/ADHD:**
Mental Health Behavioral Issues	☐	☐	**Specify:** **Treatment/Medication:**
Wears Glasses/Contacts	☐	☐	☐**Glasses** ☐**Contacts** → ☐**For Distance** ☐**For Reading**
Hearing Loss	☐	☐	☐**Hearing Loss Right Ear** ☐**Hearing Loss Left Ear** ☐**Hearing Aid(s)**
Other Serious Illness	☐	☐	**Specify:** **Date of Onset:**
Serious Injury	☐	☐	**Specify:** **Date(s):**
Surgery	☐	☐	**Specify:** **Date(s):**
Medication Taken at Home ***(if not already listed)***	**List:**		

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstance.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE *PRINTED NAME* *DATE*

Rev. 4/2009 *Reviewed by School Nurse:* .....