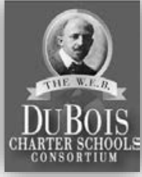

Coordinated School Health
Confidential Student Health Information

PLEASE PRINT

Student Name ____
Gender: M or F **Date of Birth: ___ M ___ D ____YR.**
School: ____
Teacher: _____________________________ **Grade:** _________

General Information:

The respect for identifiable health information will enable us to provide safe and appropriate health care if your child becomes ill or injured at school or on the bus. The information that you provide will be maintained confidentially and is limited to individuals that work with your child within the school setting with a legitimate need to know. If you have any questions or would like to discuss specific health issues with Health Services staff, please call your school directly during school hours.

RELEASE OF HEALTH INFORMATION (PLEASE INITIAL)

	Parent/legal guardian **gives** permission to release health information to appropriate school system staff for medical alert information and health care management.
	Parent/legal guardian **prohibits** disclosure of sensitive health information to school staff unless medically necessary without specific request and school nurse involvement.

PARENT/LEGAL GUARDIAN INFORMATION (PLEASE PRINT)

Last Name	First Name	Relationship	Phone

EMERGENCY CONTACTS (PLEASE PRINT)

Last Name	First Name	Relationship	Phone

PHYSICIAN CONTACTS (PLEASE PRINT)

Physician's Name or Office	Clinic/Practice Name & Address	Phone

PLEASE REVIEW THE FOLLOWING LIST AND CHECK ANY AND ALL THAT APPLY:

	ADHD		Cystic Fibrosis		Kidney Problem		Sickle Cell Anemia
	Anemia		Diabetes		Leukemia		Sinus Problems
	Anxiety Attack		Depression		Low Blood Pressure		Stroke
	Arthritis		Dialysis		Meningitis		Vision Problems
	Artificial Joints		Fractures (Skull)		Menstrual Cramps		Vomiting
	Artificial Valves (Heart)		Glasses		Migraine Headache		Procedure:
	Asthma		Headaches		Nosebleeds		Catheterization**
	Back Problems		Hearing Problems		Panic Attacks		Tube Feeding**
	Broken Bones		Heart Problems		Reflux		Equipment:
	Cancer		Hemophilia		Rheumatic Fever		Crutches
	Contact Lens		High Blood Pressure		Scoliosis		Walker
	Concussion		Hypoglycemia		Seizures		Wheelchair
Other, including health procedures:							
**If any are checked, please provide specific information:							

PLEASE COMPLETE REVERSE SIDE

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ALLERGY INFORMATION: IS YOUR CHILD ALLERGIC TO ANY OF THE FOLOWING?

	Medication (name)	Environmental – (Trees – Grass)	Does your child require an Epinephrine for an allergic reaction? Y or N If Yes, what type and dose level:	Name of medications your child takes in addition to the Epinephrine to treat an allergic reaction:
	Food (Tree nuts – Peanuts – Fish – Milk)	Dyes (Red – Yellow)		
	Insects (Bees – Wasps)	Other		
	Latex			

MEDICATION INFORMATION: DOES YOUR CHILD ROUTINELY TAKE MEDICINE AT HOME OR SCHOOL? Y OR N

IF YES, PLEASE PROVIDE INFORMATION BELOW:

DIAGNOSIS FOR WHICH MEDICINE IS GIVEN	NAME OF MEDICATION	FORM (PILL, LIQUID, INHALER)	DOSAGE	SPECIFIC TIME(S) TO BE GIVEN	GIVEN AT HOME	GIVEN AT SCHOOL

PARENT/LEGAL GUARDIAN ACKNOWLEDGEMENT: I understand that my child may be allowed to take his/her medication according to Du Bois Consortium/ SCS Health Care Management Policy #6043. I also understand that I must personally bring all medications that are deemed medically necessary for administration during the school day to the school and complete a Parent Authorization Form for Administration of Medication. This document will be placed on file in the school office.

I understand that although a reasonable attempt will be made to remind the student about medications, it is expected that the student will be responsible for obtaining his/her medication if required for self-administration during the school day.

I agree to indemnify and hold harmless Du Bois Consortium and its employees from claims relating to the possession or self-administration of asthma inhalers, and understand that Du Bois Consortium, its employees and agents shall incur no liability as a result of injury to a student or any other person as a result of possession or self-administration of asthma inhalers.

I also authorize the school nurse to consult with the prescribing physician to clarify medication orders, or in the interest of the student's health, to discuss his/her response to the prescribed medication. All health information will be kept confidential.

________________ ____ ____________________

Date | Parent/Legal Guardian Signature | Telephone

FOR SCHOOL STAFF ONLY

Note: The School Nurse will review this form to determine the level of disclosure and appropriate action:

Medical Alert _____ IHP to be developed _____ Other ____

School Nurse review date and signature: ____

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