

STUDENT HEALTH HISTORY 2010-2011

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: _____ SOCIAL SECURITY NUMBER: _____

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'S PHONE NUMBER _____

CHECK ANY THAT APPLY TO YOUR CHILD

PLEASE DESCRIBE

- | | |
|--------------------------------------------------------------------------------------------------------|-----------|
| 1. <input type="checkbox"/> Eye or Vision problems | 1. _____ |
| 2. <input type="checkbox"/> Ear/Hearing problems | 2. _____ |
| 3. <input type="checkbox"/> Lung/Breathing problems, asthma, etc. | 3. _____ |
| 4. <input type="checkbox"/> Heart problems/surgery/blood pressure problem | 4. _____ |
| 5. <input type="checkbox"/> Kidney/bladder problems, surgery, etc. | 5. _____ |
| 6. <input type="checkbox"/> Bone, joint or muscle problems | 6. _____ |
| 7. <input type="checkbox"/> Neurological problems, seizures, etc. | 7. _____ |
| 8. <input type="checkbox"/> Spine or back problems, surgery, etc. | 8. _____ |
| 9. <input type="checkbox"/> History of emotional/mental health problems treatments or hospitalizations | 9. _____ |
| 10. <input type="checkbox"/> Alcohol/drug use/abuse or treatment | 10. _____ |
| 11. <input type="checkbox"/> Diabetes | 11. _____ |
| 12. <input type="checkbox"/> Cancer | 12. _____ |
| 13. <input type="checkbox"/> ADD/ADHD | 13. _____ |
| 14. <input type="checkbox"/> Sickle Cell Disease or bleeding disorders | 14. _____ |
| 15. <input type="checkbox"/> Cystic Fibrosis | 15. _____ |

16. List **any chronic or long term condition** _____
17. List any surgery, date and reason _____
18. List any hospitalization in the past five years _____
19. List **any restrictions on activity/physical handicaps** _____
20. List **all daily medication your child takes** _____
21. List all **allergies to medications**, food products or insect stings your child has _____

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
- * Immunization status and health history reviews
- * Vision, hearing, height-weight, dental and scoliosis screenings
- * Age appropriate reproductive health counseling
- * 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

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: _____