

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 1 st :		Home: _____	Cell: _____
		Work: _____	
Call 2 nd :		Home: _____	Cell: _____
		Work: _____	
Call 3 rd :		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	<input type="checkbox"/>	<input type="checkbox"/>	List: _____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Food(s): <input type="checkbox"/> peanut <input type="checkbox"/> dairy <input type="checkbox"/> eggs <input type="checkbox"/> other _____ Rate the reaction: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> life-threatening Does your child require an EpiPen? <input type="checkbox"/> yes <input type="checkbox"/> no
Allergy to Bees Stings	<input type="checkbox"/>	<input type="checkbox"/>	Rate the reaction: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> life-threatening Does your child require an EpiPen? <input type="checkbox"/> yes <input type="checkbox"/> no
Allergies (other)	<input type="checkbox"/>	<input type="checkbox"/>	List: _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rate the severity: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> life-threatening Asthma medication taken at home: _____ Medication required at school: _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type 1 (Insulin Dependent) <input type="checkbox"/> Type 2 Diabetes medication(s) taken at home: _____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Type of Seizure: _____ Medications: _____
Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____ Treatment: _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____ Treatment: _____
Bowel/Bladder Issues	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Triggers: _____ Treatment: _____
Bone/Muscle Problems	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____ Activity Restrictions: _____
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Medication for ADD/ADHD: _____
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
Behavioral Issues	<input type="checkbox"/>	<input type="checkbox"/>	Treatment/Medication: _____
Wears Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts → <input type="checkbox"/> For Distance <input type="checkbox"/> For Reading
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hearing Loss Right Ear <input type="checkbox"/> Hearing Loss Left Ear <input type="checkbox"/> Hearing Aid(s)
Other Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____ Date of Onset: _____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____ Date(s): _____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	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 _____