



**Calhoun County Public Health Department School Wellness Program**  
**Student Health Information**  
 2013-2014 School Year



Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Initial Male Female

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City Zip

**Race (Please check one)** Caucasian  African American  Native American  Asian  Other/Multi   
**Ethnicity (Please check)** Hispanic  Multi Ethnic  Middle East  Native Am  Other \_\_\_\_\_

**Does student have health insurance?** Medicaid  Private  None   
 If None, would you like information on Healthy Kids, MICHild, or Calhoun County Health Plan? Yes  No

Doctor's Name \_\_\_\_\_ Date of last physical \_\_\_\_\_  
 Dentist's Name \_\_\_\_\_ Date of last dental exam \_\_\_\_\_

**Does student have any of the following (please check)?**

**Allergies** Yes  No  **To drugs, pollen, etc? List** \_\_\_\_\_  
**Does reaction require emergency treatment?** Yes  No   
**Comments** \_\_\_\_\_

**Bee Sting Allergy** Yes  No  **Describe reaction** \_\_\_\_\_  
**Use Bee Sting Kit?** Yes  No  **Difficulty Breathing?** Yes  No

**Asthma** Yes  No  **Treatment Needed** \_\_\_\_\_ **Triggered by** \_\_\_\_\_  
**Diagnosed by Doctor?** Yes  No  **Emergency plan at school?** Yes  No   
**Use inhaler/nebulizer?** Yes  No   
**Inhaler/nebulizer is available at school?** Yes  No

**Diabetes** Yes  No  **Takes insulin?** Yes  No  **Emergency plan at school?** Yes  No   
**List range of desired blood sugar** \_\_\_\_\_

**Epilepsy/Seizures** Yes  No  **Describe seizure** \_\_\_\_\_  
**Medication** \_\_\_\_\_ **Last seizure (date)** \_\_\_\_\_

**Heart Condition** Yes  No  **Describe** \_\_\_\_\_  
**Physical Restrictions?** \_\_\_\_\_ **Medication** \_\_\_\_\_

**Chicken Pox** Yes  No  **Month** \_\_\_\_\_ **Year** \_\_\_\_\_  
**List any serious illnesses, surgeries or injuries in the past 12 months** \_\_\_\_\_

**Eyes** Glasses  Contact Lenses  Other \_\_\_\_\_  
**Ears** Tubes  Frequent Infections  Hearing Aid  Difficulty Hearing (Explain) \_\_\_\_\_

**Other (check those that apply)**

ADD/ADHD <input type="checkbox"/>	Dental Problems <input type="checkbox"/>	Nosebleeds <input type="checkbox"/>
Birth Defects <input type="checkbox"/>	Eating Disorder <input type="checkbox"/>	Skin Problems <input type="checkbox"/>
Bladder/Bowel Problems <input type="checkbox"/>	Headaches <input type="checkbox"/>	Sleeping Problems <input type="checkbox"/>
Blood Pressure Problems <input type="checkbox"/>	Menstruation Problems <input type="checkbox"/>	Special Education <input type="checkbox"/>
Blood Disorder (for example sickle cell disease) (Describe) _____	Mental Health Issues <input type="checkbox"/>	

**Other health information or concerns?** \_\_\_\_\_

**What medications are taken regularly at school?**

Medication _____	Dose _____	Purpose _____
Medication _____	Dose _____	Purpose _____
Medication _____	Dose _____	Purpose _____

**What medications are taken regularly at home?**

Medication _____	Dose _____	Purpose _____
Medication _____	Dose _____	Purpose _____
Medication _____	Dose _____	Purpose _____



Calhoun County Public Health Department
School Wellness Program

Consent for Treatment

2013-2014 School Year



Student Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Allergies (please list) \_\_\_\_\_

I give my permission for my child to receive health screenings, basic health care treatment, health education, emergency care, and to receive any of the medications listed below as deemed necessary by the Calhoun County Public Health Department (CCPHD) School Nurse.

- OTC Antibiotic Ointment
OTC Antihistamine Cream
Acetaminophen (Tylenol)
Ibuprofen (Advil)
Cough Drops/Throat Lozenges
Eucerin Lotion (for Dry Skin)
Chewable Antacid Tablets (Tums) age appropriate
Caladryl/Calamine Lotion
OTC Cortisone Cream
Wound/Antiseptic Wash
Saline Eye Drops (Non-Medicated)
Benadryl (orally for allergic reaction)
Silvadene Cream (for burns)

I understand that the above medications will be administered by the Registered Nurse/School Nurse in accordance with established protocols developed by the CCPHD School Wellness Program.

- In addition to the above medications, I give the school nurse permission to administer medications that are given during the school day per school policy.
I understand that the School Nurse will only share pertinent information with school staff or medical providers (allergies, chronic conditions, etc.) on a need to know basis.
I have been given or have had the opportunity to review the CCPHD Privacy Notice, and may have a copy upon request.
I verify that I am authorized to sign consent for the person named in this document.
The Calhoun County Public Health Department has occasion to use photographs of students and school nurses in our presentations to promote our School Wellness Program to community members and funding partners.

Yes [ ] No [ ]

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mother/Guardian \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Father/Guardian \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

EMERGENCY CONTACT INFORMATION – This must be completed with someone other than parent above.

Name (print): \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\*THIS CONSENT WILL BE IN EFFECT FOR THE 2013-2014 SCHOOL YEAR OVER (COMPLETE BOTH PAGES OF THIS FORM)