Calhoun County Public Health Department School Wellness Program

Student Health Information

2014-2015 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 & Phone_____ **Date of last physical**_____
Dentist's Name & Phone _____ **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 ☐
Emergency Plan at school? Yes ☐ No ☐
Comments_____

Bee Sting Allergy Yes ☐ No ☐ **Describe reaction**_____
Use Bee Sting Kit? Yes ☐ No ☐ **Difficulty Breathing?** Yes ☐ No ☐
Emergency Plan at school? 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**_____ **Last Seizure (Date)**_____
Medication_____ **Emergency Plan at school?** Yes ☐ No ☐

Heart Condition Yes ☐ No ☐ **Describe** _____
Physical Restrictions? _____**Medication**_____

List any serious illnesses, surgeries, injuries or concussion 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	☐	Dental Problems	☐	Nosebleeds	☐
Birth Defects	☐	Eating Disorder	☐	Skin Problems	☐
Bladder/Bowel Problems	☐	Headaches	☐	Sleeping Problems	☐
Blood Pressure Problems	☐	Menstruation Problems	☐	Special Education	☐
		Mental Health Issues	☐		

Blood Disorder (for example sickle cell disease) (Describe) _____

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_____

Parent/Guardian Signature:_____ ***Date:***_____

OVER (COMPLETE BOTH PAGES OF THIS FORM)

Calhoun County Public Health Department
School Wellness Program

Consent for Treatment

2014-2015 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, and emergency care. In addition, the school nurse may administer any of the medications listed below in accordance with established protocols developed by the Calhoun County Public Health Department School Wellness Program.

- 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 Prescribed Medications require the **Medication Administration Authorization Form** to be completed by the Parent & Physician prior to administration. ALL medications must be in the original, properly labeled container & dispensed by a physician/pharmacist.

- 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.

- I further consent to release of information to my child's primary/specialist care provider regarding follow-up care for assessment/treatment provided.

- I understand that I may withdraw my consent at any time during the school year by contacting the health office.

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:** _____

- 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. Photographs may be used in brochures, posters, newspaper articles, power point presentations, and as part of our annual report to the school community. I grant Calhoun County Public Health Department and it respective agents, employees, officers, and representatives the right, but not the obligation to incorporate or use still photograph(s) in any manner the county sees fit.
  Yes, I give consent for photos ☐ *Initial*_____ *No, I don't give consent for photos* ☐ *Initial*_____

THIS CONSENT WILL BE IN EFFECT FOR THE 2014-2015 SCHOOL YEAR

OVER (COMPLETE BOTH PAGES OF THIS FORM)