STUDENT HEALTH INFORMATION SHEET

All information obtained for this purpose will remain confidential. One form per student enrolled is required.

Name of Student: ____ Grade: _____

Date of Birth:________________________ Student's Age: ________

HEALTH HISTORY: Select **Yes** for any conditions that apply to your child and have been diagnosed by a physician.

CONDITION COMMENTS

ADHD: Yes_____ No_____

ADD: Yes_____ No_____

Allergies: Yes_____ No_____

Asthma: Yes_____ No_____

Bladder/Bowel Issues: Yes_____ No_____

Blood Disorder: Yes_____ No_____

Bone/Muscle Issues: Yes_____ No_____

Cancer: Yes_____ No_____

Celiac Disease: Yes_____ No_____

Chickenpox: Yes_____ No_____

Diabetes: Yes_____ No_____

Kidney: Yes_____ No_____

Heart Disease: Yes_____ No_____

Hepatitis: Yes_____ No_____

Immune Disorder: Yes_____ No_____

Mental/Behavioral Health: Yes_____ No_____

Migraine: Yes_____ No_____

Neurological: Yes_____ No_____

Scoliosis: Yes_____ No_____

Seizures: Yes_____ No_____

Surgery: Yes_____ No_____

Other: Yes_____ No_____ ____

Other: Yes_____ No_____ ____

Prescription medication to be given at school must be in the original bottle with the child's name and instructions for administration on the label. A permission form must be signed by the parent or guardian and kept on file in the nurse's office. In accordance with the Nurse Practice Act, a health plan must be developed for administering care for any ongoing chronic condition (i.e. diabetes, asthma, epilepsy etc.)

MEDICATIONS

Is your child prescribed an epinephrine injector such as Epi-Pen®? Yes_____ No_____

Comments:

Is your child on any prescriptive medications? Yes_____ No_____ If yes, state the name of the medications(s) and the reason it is being given:

Will the medication be given at schoo?l Yes_____ No_____

Does your child have a vision problem? If yes, please describe: Yes_____ No_____

Does your child wear glasses? Yes_____ No_____

Does your child wear contacts? Yes_____ No_____

Is there a hearing loss or deafness ? Yes_____ No_____ Left ear? Right ear? Both?

Does the child wear a hearing aid(s)? Yes_____ No_____

When a child suffers any injury or illness while in school, an immediate and continuing effort will be made to contact parents. In cases of serious injury or illness, first aid will be rendered in accordance with local school policies.

EMERGENCY HEALTHCARE CONSENT: I represent that I am a person who has the right to consent to medical, dental, psychological, and surgical treatment on behalf of the identified student. I authorize

Round Top-Carmine ISD to contact the person(s) identified by the student's parent(s)/guardian(s) as emergency contact(s). In the event that the student's parent(s), legal guardian(s), emergency contact(s) and/or nonparent adult caregiver(s) authorized by Texas Family Code Chapter 34 cannot be immediately contacted by telephone, I authorize the to consent to medical, dental, psychological, and surgical treatment on behalf of the student.

Parent Signature:____ Date:____________________

NOTE: In the event the consents to treatment of the student pursuant to this authorization, Round Top-Carmine ISD is immune from any and all liability for damages or amounts incurred, including the cost of emergency care or transportation, resulting from the examination or treatment of the identified student.

Hospital Preferred:____

Physician Name and Phone Number:____

SIBLING NAMES	GRADE	CAMPUS

Round Top-Carmine ISD does not discriminate against any person because of race, color, religion, sex, national origin, disability, age, or on any other basis prohibited by law.