**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 [ ] **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 seizue\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Seizure (Date)\_\_\_\_\_\_\_\_\_\_** |
|  |  | **Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Plan at school?** Yes [ ]  No [ ]  |
| **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)** | Dental Problems [ ]  | Nosebleeds [ ]  |
|  | ADD/ADHD [ ]  | Eating Disorder [ ]  | Skin Problems [ ]  |
|  | Birth Defects [ ]  | Headaches [ ]  | Sleeping Problems [ ]  |
|  | Bladder/Bowel Problems [ ]  | Menstruation Problems [ ]  | Special Education [ ]  |
|  | Blood Pressure Problems [ ]  | Mental Health Issues [ ]  |  |
|  | Blood Disorder (for example sickle cell disease) (Describe)  |
| **Other health information or concerns?**  |
| **What medications are taken regularly at school?** |  |  |
|  Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Puropse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **What medications are taken regularly at home?** |  |  |
|  Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| **OVER (COMPLETE BOTH PAGES OF THIS FORM)** |

**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, 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 Deptartment School Wellness Program.

|  |  |
| --- | --- |
| * OTC Antibiotic Ointment
 | * Chewable Antacid Tablets (Tums) age appropriate
 |
| * OTC Antihistamine Cream
 | * Caladryl/Calamine Lotion
 |
| * Acetaminophen (Tylenol)
 | * OTC Cortisone Cream
 |
| * Ibuprofen (Advil)
 | * Wound/Antiseptic Wash
 |
| * Cough Drops/Throat Lozenges
* Eucerin Lotion (for Dry Skin)
 | * 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 & Physicianprior 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 understand that I may withdraw my consent at any time during the school year by contacting the health office.
* 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 Initial\_\_\_\_\_\_\_\_\_\_\_\_ No Initials \_\_\_\_\_\_\_\_\_\_\_\_\_

  **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)**