Tate County School

Student Health Record

Student Name: ____ Grade: ________________

Date of Birth: _____________ Age: _____ Height (Feet / Inches): _______'/______" Weight (lbs): _________ Male × Female ×

Father / Mother/Guardian: _____________________________________ Address: ____

Cell #: ______________________ Home #: ___________________ Work#: ____________________ E-Mail: ______________________

Emergency Contact Person: ____________________________________ (relationship) __________ Phone #: __________________

Social Security #: ____ Medicaid #: _________________________________ Health Ins.: ____________________

Problem	Yes	No	Problem	Yes	No
Any medication (including but not limited to asthma inhalers and epi pen) MUST have signed MD orders and given to the nurse.					
Has Allergies to MEDICATION(S) | List medication(s) & type of reaction on back of this form)			Emotional/Psychological disorder		
Has Allergies to food(s) | List food(s) & type of reaction on back of this form			Headaches (frequent or takes medicine)		
Has Allergies to insects' bites or stings | List type of reaction on back of this form)			Heart problem (murmur or defects-list on back of this form)		
Carries or has Emergency Medications | List medications on back/ **If yes, a signed physician order is required and must be on file at the school.**			Hypertension (high blood pressure)		
Asthma (Circle: Mild/ Moderate/Severe) **If yes, An Asthma Action Plan is REQUIRED from a physician & is to be provided to the school**			Lice (Recent or currently known problem)		
Attention deficit (ADD, ADHD) | list medications on back of this form			Nose bleeds (List frequency on back of this form)		
Birth defect/physical handicap			Sinus problems		
Bone or joint problems			Speech and/or Hearing problems		
Convulsions (seizure/epilepsy-List Type, symptoms, routine/emergency med's on back)			Vision (seeing) problems: Glasses or contacts? Date Last seen by ophthalmologist?		
Diabetes (Note on back if requires insulin pump?)			Surgery (List types and dates on back of this form)		
Earaches | List frequency/Tubes-Date:			Stomach or digestive problems		

Describe any handicaps or special needs of student: ____

Is the student taking any daily prescription or OTC medication at home? Yes × No × If yes, please list on back.

Student's Healthcare Provider(s): _________________________________Phone #: ____________________Fax: ___________________

_________________________________Phone #: ____________________Fax: ___________________

CONSENT

I/We give permission for my/our child to participate in the school's health program which includes health education and health basic screenings (Vision, Hearing, Scoliosis, Lice, Height, Weight, Body Mass Index etc). I hereby give permission for my child to receive medical treatment for first aid or emergency care or examination and treatment by the school nurse practitioner, collaborative physician, nurse, or a trained and approved staff member delegated by the school principal as needed per Tate County School District Policy or as recommended by the nurse practitioner or collaborative physician.

YES × NO ×

I/We give my/our consent for pertinent medical information to be shared between the student's medical provider or pharmacist and the school nurse/nurse practitioner and/ or any other school personnel directly involved with my child at school.

YES × NO ×

I/We give my/our consent for release of pertinent medical records from the student's Healthcare provider(s) listed above to the school nurse/nurse practitioner and/or any other Tate County School personnel directly involved with my child at school.

YES × NO ×

Parent/Guardian Signature(s) ___________________________________Date: ____