Calhoun County Public Health Department School Wellness Program
Student Health Information

Teacher_____ **Grade**_____

Student Name _____ **Birth Date** _____/_____/_____
Last *First* *Middle Initial*
☐ **Male** ☐ **Female**

Address_____ **Phone**_____
Street *City* *Zip*

Race ☐ White/Caucasian ☐ Black/African American ☐ Native American ☐ Asian ☐ Other/Multiple
Ethnicity ☐ Non-Arabic/Non-Hispanic ☐ Hispanic ☐ Arabic ☐ Native American ☐ Other

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

Does student have a doctor that they see regularly? ☐ Yes ☐ No

Doctor's Name & Phone_____ **Date of last physical**_____

Does Student Have Any Of The Following:

Medication Allergies: _____ Prescription or Over The Counter	Emergency Treatment Needed ☐ Yes ☐ No	Treatment _____
Seasonal Allergies:_____	Emergency Treatment Needed ☐ Yes ☐ No	Treatment _____
Food Allergies: _____	Emergency Treatment Needed ☐ Yes ☐ No	Emergency Plan and Medication at School ☐ Yes ☐ No
Sting Allergies: _____	Emergency Treatment Needed ☐ Yes ☐ No	Emergency Plan and Medication at School ☐ Yes ☐ No
Asthma Triggered by:_____	Inhaler ☐ Yes ☐ No Nebulizer ☐ Yes ☐ No	Emergency Plan and Medication at School ☐ Yes ☐ No
Diabetes Desired Blood Sugar Range: _____	Uses Insulin ☐ Yes ☐ No	Emergency Plan and Medication at School ☐ Yes ☐ No
Epilepsy/Seizure Disorder Last Seizure: _____ Describe Seizure: _____	Medication ☐ Yes ☐ No	Emergency Plan at School ☐ Yes ☐ No
Heart Condition Describe_____	Medication ☐ Yes ☐ No _____	Restrictions ☐ Yes ☐ No

List any serious illnesses, surgeries, injuries or concussion_____
_____

Eyes ☐Glasses ☐Contact Lenses Other _____
Ears ☐Tubes ☐Frequent Infections ☐Hearing Aid ☐Difficulty Hearing (Explain)_____

Other (check those that apply)

☐ ADD/ADHD
☐ Birth Defects
☐ Bladder/Bowel Problems
☐ Blood Pressure Problem
☐ Blood/Bleeding Disorder
☐ Dental Problems
☐ Eating Disorder
☐ Headaches
☐ Menstruation Problems
☐ Mental Health Issues
☐ Nosebleeds
☐ Skin Problems
☐ Sleeping Problems
☐ Special Education

Describe anything checked above: _____

What medications are taken regularly?

Medication:_____ Dose:_____ Time:_____ Purpose:_____
Medication:_____ Dose:_____ Time:_____ Purpose:_____
Medication:_____ Dose:_____ Time:_____ Purpose:_____
Medication:_____ Dose:_____ Time:_____ Purpose:_____

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

⇒ **OVER (COMPLETE BOTH PAGES OF THIS FORM)** ⇒

Calhoun County Public Health Department School Wellness Program
Consent for Treatment

Student Name_____Birthdate_____/_____/_____

I give my permission for my child to receive health screenings, BMI measurement/data collection, basic health care treatment, and emergency care. In addition, the school nurse may administer over the counter medications including but not limited to ibuprofen, acetaminophen and loratadine in accordance with established protocols developed by the Calhoun County Public Health Department School Wellness Program (SWP).

I understand that testing for blood borne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to blood or body fluids.

I have been given or have had the opportunity to review the CCPHD Privacy Notice (located at https://www.calhouncountymi.gov/government/health_department/school_wellness/ and may also be provided a copy upon request.

I understand that All Medications to be administered by school staff or are self-carried by the student 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, or be in the original over the counter packaging.

I further consent to release of information to my child's primary/specialist care provider, and school personnel regarding follow-up care for assessment/treatment provided, coordination of care or school services.

For Parents/Guardians – I give consent for my student to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I will update the student health information annually as warranted by changes in medical condition. I understand that I may withdraw my consent at any time during the school year by contacting the health office.

I verify that I am authorized to sign consent for the person named in this document

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 occasionally uses 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*_____

⇒ **OVER (COMPLETE BOTH PAGES OF THIS FORM)** ⇒