HITCHCOCK INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
STUDENT HEALTH HISTORY AND EMERGENCY CONSENT

If your child has been diagnosed with an acute or chronic medical condition, or any changes occur during the school year, be certain to contact your school clinic staff.

In an effort to provide safe, informed care for your child at school, the HISD Health Service Department requires the following information to complete your child's enrollment. Medical information you provide about your child is a confidential education record. HISD keeps all medical information about your child confidential as required by law. However, health information about your child may be communicated and displayed as a medical alert in the HISD TxEIS system to school personnel on a need to know basis for the educational, health and safety of your child.

PLEASE PRINT:

Student Name _____ **Gender (circle one) M F**
Last First Middle

DOB: _____ **Home #** _____ **Grade:** _____

Parent/Guardian Name _____**Cell #**_____ **Work #** _____

Child's Health Care Provider_____ **Phone #**_____

Health Care Provider Address _____

PLEASE MARK/CIRCLE ANY OF THE FOLLOWING THAT APPLY (1-16):

_____ **MY CHILD HAS NO KNOWN HEALTH CONDITIONS**

_____ **MY CHILD HAS NO KNOWN ALLERGIES**

_____ I certify that my child had chickenpox on or about _____ and does not need the Varicella (chickenpox) Vaccine. (month/year)

HEALTH CONDITIONS DIAGNOSED BY HEALTH CARE PROVIDER: (circle number and specify if pertains to your child)

1. Abdominal (Irritable Bowel Syndrome, gastric reflux, constipation):_____
2. **ALLERGIES:** FOOD TYPE:_____MEDICATION TYPE:_____INSECT TYPE:_____
   REACTION:_____
   Does your child require an EMERGENCY MEDICATION for an allergic reaction at school? YES / NO
   IF YES, LIST MEDICATION:_____
   PARENT/GUARDIAN MUST PROVIDE ANY/ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS). HISD WILL NOT PROVIDE NOR PURCHASE ANY OVER-THE-COUNTER MEDICATIONS PER DISTRICT POLICY.
3. **ASTHMA**: Does your child require an inhaler: **YES / NO** List medication, time and dosage:_____
   Does your child use a nebulizer: **YES / NO** List medication, time, dosage: _____
   Last ER visit due to asthma attack:_____ Last hospitalization due to asthma attack:_____
4. Blood Disorders (sickle cell anemia, clotting disorders): _____
5. Cancer: _____
6. Diabetes (Type 1, Type 2):_____
7. Dietary needs/restrictions: _____
8. Ear, Nose, and throat (frequent nosebleeds, ear infections, hearing loss, tubes):_____
9. Heart Condition (heart defect, high blood pressure, irregular heart beat), specify: _____
10. Mental Health (ADD, ADHD, depression, bipolar, OCD, etc.), specify and list medications below:_____
11. Nerve/Muscle/Bone Disorder, (specify):_____
12. Neurological (seizures, migraines, cerebral palsy), specify:_____
13. Past surgeries/hospitalizations (month/year), specify:_____

STUDENT NAME:_____**DOB:**_____**GRADE:**_____
Last, First, Middle (printed)

14. Pregnancy (current/recent, EDD, OB/GYN, Hospital for delivery, complications, etc.):_____
15. Respiratory (cystic fibrosis):_____
16. Vision impairment (glasses/contacts, blindness, prosthesis, eye surgeries; specify which eye involved):

    _____
17. Other:_____

OTHER HEALTH CONDITIONS/RESTRICTIONS:

Please list restrictions in Physical Education or in any physical activity, wheelchair accommodations, recent major illness or injury, recent or ongoing medical treatment, etc. **Physician's note required to support restrictions**.

_____

SPECIALIZED PROCEDURES:

Please contact the school clinic staff if your child requires a special procedure (e.g., catheterization, tube feeding, glucose monitoring, nebulizer, etc.) as a separate permission form is required. _____

_____

MEDICATIONS: My child takes the following prescription medications:

Name of Medication	Dosage (strength/quantity)	Reason/Diagnosis	At home	**At School** (specify time)

Medications are strongly encouraged to be taken at home around school hours with exception of Asthma inhalers, Anaphylactic emergency medications, and Insulin (ie: three times daily meds…before school, after school, and at bedtime).

Any medication needed at school, MUST be brought to the school clinic by parent/guardian. All medications must be provided by parent/guardian. District policy NOW **requires PHYSICIAN'S PRESCRIPTION for all medications that must be administered at school. A separate permission/consent form is required for each medication and is available in the school clinic. All medication must be provided in the original PRESCRIPTION container and label, student specific, name of medication, dosage and duration. PRESCRIPTION MUST BE CURRENT (within 12 mos. and non-expired). At the end of every school year all medications must be picked up by the last day of school, otherwise, all medications not picked up will be destroyed. **In order to better protect your child and prevent any unknown allergic reactions OR mask any underlying health issues, ALL OVER-THE-COUNTER (OTC) MEDICATIONS (Ex: Tylenol, Ibuprofen) will no longer be administered during school hours or school sponsored events. ALL MEDICATIONS MUST BE PRESCRIPTION IN ORDER TO BE ADMINISTERED AT SCHOOL.**

IN THE EVENT OF AN EMERGENCY, I HEREBY AUTHORIZE HITCHCOCK INDEPENDENT SCHOOL DISTRICT OFFICIALS TO SECURE MEDICAL TREATMENT. I UNDERSTAND THE STUDENT IS GENERALLY TRANSPORTED BY AMBULANCE TO THE NEAREST EMERGENCY CARE FACILITY. I WILL NOT HOLD THE SCHOOL DISTRICT OR ITS EMPLOYEES FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND/OR TRANSPORTATION FOR SAID STUDENT.

Parent/Legal Guardian Signature:_____ Date:_____

Parent/Legal Guardian Printed Name: _____