Calallen ISD HEALTH SERVICES STUDENT ANNUAL HEALTH HISTORY

STUDENT ID: _____ **HOMEROOM TEACHER:** _____ **GRADE:** _____

Last Name_____ First_____ MI____DOB: _____ Sex: _____

Address: _____Phone: _____

Mother: _____Work: _____ Cell: _____

Father: _____Work: _____ Cell: _____

Emergency contacts who can assume responsibility for your child: **MUST COMPLETE THIS INFORMATION WITH TWO CONTACTS:** (Please make sure these are **additional** phone numbers to the ones listed above)

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Physician Information:

Student's Doctor: _____Phone_____

Student's Doctor: _____Phone_____

PLEASE COMMENT ON STUDENT'S CURRENT HEALTH PROBLEM(S)

Life Threatening AllergiesEPIPEN, Doctor's Order and Action Plan REQUIRED****

☐ **Insects- BEES/WASPS/ANTS** ☐ **Food Allergy** _____ ☐ **Latex** ☐ **Other**_____

☐**ADD/ADHD-** Medication_____ ☐Given at Home ☐ Given at School ☐ None Given at this Time

☐**Asthma**- ☐Student will carry Inhaler ☐ Inhaler will be in Clinic *Action Plan Required* ☐ No Medication Needed

☐**Diabetes**-☐ **Type I** ☐ **Type II** ☐ **Other** **Medical Management Plan Required**

☐ **Seizure Disorder** Date of last Seizure: _____ ***Action Plan Required***

I f NO CURRENT HEALTH PROBLEMS:_____(Parents PLEASE INITIAL)

***PLEASE LIST ANY Other DAILY MEDICATIONS:** _____

***Will any Medication be taken at school:** ☐ Yes ☐ No If yes, Doctor's Order Required

Is there anything we need to know about your child's health not yet asked? ☐ Yes ☐ No If yes, please explain:

_____

_____

I, the undersigned, do hereby authorize officials of CISD to contact directly the persons named on this form, and do authorize the physician(s) named to render such treatment as may be deemed necessary and I give permission for the exchange of medical information between the health care team and educational staff for the health of said child.

In the event the parents, physician, or other persons named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health and safety of the aforesaid child. I will not hold the school district financially responsible for the emergency and/or transportation for the said child.

Does student have any siblings on other Calallen Campuses? If so please list Name(s), Grade(s) and Campus:

1._____ **2.**_____

3._____ **4.**_____

*********If any of the above information changes please contact your Campus Nurse.**********

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

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Calallen ISD
Health Services

Parent/Guardian:

Below is a regulation regarding the consent to contact your child's health care provider if needed, in order to better provide school health related services. In order to begin or continue to provide this service to your child, this consent must be on file. The regulation is provided below. Please sign and return this document to the school nurse, so we can provide continuity of care to your child.

Regulation

Consent to communicate with medical health care professional or health care provider:

"Written consent must be obtained from a student's parent/guardian allowing the District's designee, including District medical professionals, to share/obtain a student's health related information with the medical health professional or health care provider identified by the parent/guardian, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other CISD form requesting school health care services. School related health services will not be provided to a student without the required consent of the parent/guardian, as outlined herein."

Consent

I consent for the District's designee, including District medical professionals, to share/obtain my student's health related information with the medical health professional or health care provider identified below, in order to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other CISD form requesting school health care services. I understand that school related health services will not be provided to my student without my required consent, as outlined herein.

Thank you.

Parent/Guardian:

Printed Name _____ Signature _____ Date _____

Email Address _____ Phone/Cell Number _____

Student's Name (please print) _____

Provider Information:

Student's Health Care Physician _____ Phone _____
Student's Health Care Physician _____ Phone _____
Student's Health Care Physician _____ Phone _____