

**BEAUMONT INDEPENDENT SCHOOL DISTRICT
Health Services
Health History/Health Information (HIPAA)**

Date Enrolled

Grade

Dear Parent/Guardian:

Please complete this form CAREFULLY, including DETAILS and return it to the school nurse. Also, please contact the school nurse if your child has a serious health issue and/or if the information needs to be updated. We would like your child gain the most from his/her school experience. In order for us to assist in this matter, it is necessary to have you fill out this form each school year.

REMEMBER - THIS INFORMATION COULD BE VERY HELPFUL IF AN EMERGENCY HEALTH SITUATION ARISES.

Pupil's Name _____

Last First I.D# Sex Birth Date

	Current		Past History		details including frequency, severity, problems, last dr. visit	last episode
	Y	N	Y	N	_____	_____
Asthma	Y	N	Y	N	_____	_____
Seizures	Y	N	Y	N	_____	_____
Heart disease	Y	N	Y	N	_____	_____
Diabetes	Y	N	Y	N	Type _____	_____
Blood Disorders	Y	N	Y	N	_____	_____

Other Conditions, Health information, or problems that you think are pertinent for school purposes:

Has your child had chicken pox disease? Y N Date: _____

List of medications :(include meds taken at home)

Previous Surgeries: Y N Date: _____ Type _____

Previous Hospital Stay Date: _____ Reason _____

Drug Allergies: Y N (List drugs and type of reaction) _____

Food Allergies Y N (List foods and type of reaction) _____

*****Note: Special dietary accommodations form must be completed and signed by a licensed physician for meal modifications.**

Check box if your child has had a physical within the last year: Date: _____ Physician/Clinic _____

If your child needs medication at school, has a heart condition, diabetes, asthma, seizures or life threatening allergy, you MUST consult with the school nurse and fill out the appropriate medical forms. The parent is responsible for notifying teacher(s) if it is necessary for each teacher to know about their child's condition. BISD has a "No Tolerance Policy" for students to be in possession of medication of any kind, including herbal supplements and vitamins- unless permission given by nurse.(see above statement).

This authorization is valid for one school calendar year. I consent to the release of medical information contained on this history form for education evaluation, program planning, health assessment, planning for health care services, and treatment in school. I give permission for necessary information related to my child's condition to be shared with the school nurse. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. This form will be maintained in the school nurse's office, separate and apart from your child's cumulative folder.

I verify that the above information is complete and accurate.

Signature of parent / guardian _____ Date: _____