CONFIDENTIAL SCHOOL HEALTH HISTORY AND CONSENT FORM

Student: _____ Race_____ Sex _____Grade/Teacher_____

1. Does your child have medical problems or receive any treatment for medical problems? _____ YES _____ NO

   If yes, Please explain: _____

2. Does your child take any medicines every day? _____YES _____ NO
   If yes, what medication: _____
3. Has your child had surgery or been hospitalized? _____ YES _____ NO
   If yes, please explain: _____
4. Has your child ever had any of the following medical problems? **Check all that apply**.

Asthma		ADD/ADHD		Cancer/ Tumor	
Diabetes		Epilepsy (Seizures)		Frequent ear infections	
Frequent headaches		Hearing loss or wears hearing aids		Hemophilia (Bleeding problem)	
Meningitis		Neurological (Brain or Spinal)		Orthopedic (Bone or Joint)	
Shortness of Breath		Skin Problems		Tuberculosis	
Urinary(Kidney or Bladder		Vision (Wears Glasses or Contacts		Emotional / Behavioral Problems	
Cardiac (Heart)		Blood Pressure		Sickle Cell	

Explain: _____

5. Is your child allergic to or unable to take ant medication (prescription or over the counter)? _____ YES ____ NO
   Please list the name and type of reaction they have had.
   Medicine(s): _____
   Type of reaction: _____
6. Food Allergy: _____ YES _____ NO Food(s): _____
   Type of reaction: _____
7. Bee or Insect(s) Allergy: _____ YES _____ NO Type of reaction: _____
8. What is your child's Doctor's name? _____ Office # _____
9. What is your child's Dentist's name? _____ Office # _____

PERMISSION FOR SERVICES

** I give my permission for my child to receive medication or medical treatment as deemed necessary by the school nurse or designated staff. Prescription medication may be given at the school with a Medication Permission form signed by a Medical Doctor with instructions for administration, parent's signature giving permission to administer medication and properly labeled container from the pharmacist.

** In case of an emergency and I cannot be reached, I would like my child transported to the nearest emergency room by Emergency Medical Services (EMS). I understand that I am responsible for all expenses associated with the emergency.

** I understand that information about my child will be shared on a "need to know" basis within the school. The school will also share information about my child with the Department of Health and Environmental Control (DHEC).

** I give my permission for my child's immunizations to be added to South Carolina Immunization Registry.

** If applicable, by signing this form, I understand that for any period when my child is eligible for Medicaid or its related programs (Partners for Healthy Children, First Choice, PEP, and other programs that may be developed), the District may bill the Medicaid program for those services and Medicaid will pay the services performed prior to the date of this consent. By signing this form, I also give the District permission to release to the Medicaid Program any information related to these services that may be necessary for the processing or auditing of Medicaid claims.

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

10. What is your child's Payment source for medical care? _____Medicaid _____ Health Insurance _____ None

RETURN TO SCHOOL NURSE

Clay Hill Elementary School

STUDENT EMERGENCY INFORMATION

Car Rider/ Bus Rider: _____

Student Name: _____Grade/Teacher:_____

DOB: _____ Race: _____Sex: ____ SS#_____Medicaid# _____

Address: _____ City/State/Zip: _____

Mother: _____ Home #_____

Cell # _____Work # _____ Other: _____

Father: _____ Home# _____

Cell# _____ Work# _____ Other: _____

STUDENT LIVES WITH? MOTHER FATHER BOTH PARENTS GUARDIAN OTHER

EMERGENCY CONTACTS:

1. Name: _____Realtionship to student: _____

   Home: _____ Cell: _____ Other: _____

2. Name: _____Realtionship to student: _____

   Home: _____ Cell: _____Other: _____

3. Name: _____Relationship to student: _____

   Home: _____ Cell: _____ Other:_____

4. Name: _____Relationship to student:_____

   Home:_____ Cell: _____ Other:_____

5. Name: _____Relationship to student:_____

   Home:_____ Cell: _____ Other:_____

Family Doctor: _____ Office #: _____

Address: _____ Fax #: _____

Name of Previous School: _____

Office #: _____ Fax #: _____