# Health History and Consent Form

Student Name_____Grade_____
Address_____ Age_____
Date of Birth_____Social Security # _____
Parent's or Guardian Name____ _____
Home Phone Number_____Daytime Phone _____
Emergency Contact: Name/Relationship _____
Phone Number_____
Medicaid or Sooner Care Number_____

**Student's Health History (circle** what applies to your Child)

Asthma
Diabetes
Seizures____ Type_____
Last Seizure_____
High Blood Pressure
Heart Disease _____
Nose Bleeds
Skin Disorder
Hearing Problems

Anxiety
Depression
Anger Problems
Drug/Alcohol problems
Suicidal Thoughts
Family Problems

Allergic to Medication: List_____

Has Student seen Counselor/Therapist? No Yes Name_____
Has Student been hospitalized for mental, emotional, or behavioral problems? No Yes

Describe any serious Health and or Mental Health issues:_____
_____

List any routine medications- include medication for emotional problems.
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I give my permission for the above information to be made available to the school nurse, school counselor, student nurses, and or designated personnel in order to assess, screen and treat health and or mental health related problems. I also give permission to give over the counter and /or prescription medications if needed. I understand service rendered may be billed to Medicaid if applicable.
Name/ relationship_____Date_____
Revised 2010