

HICKMAN COUNTY SCHOOLS

STUDENT HEALTH HISTORY INFORMED CONSENT FORM

Student Name _____ Grade _____ Date _____

Please let us know your child's health needs by completing this form.

Please check:

	<i>My child has no health problems which would affect his/her school day.</i>
	<i>My child's health needs include the conditions checked below.</i>

_____ <i>Allergies:</i> Please list (Specific drug, food, pet, or insect allergy) _____ What happens? _____ Is EpiPen prescribed? Y or N (If yes, parent must provide epipen) _____
_____ <i>Asthma:</i> Is inhaler used? Y or N If yes, how often? _____ What medications are taken for asthma? _____
_____ <i>Diabetes:</i> What medications are taken? _____ Any special procedures during the school day? _____
_____ <i>Hearing problems:</i> Please describe. _____
_____ <i>Vision problems:</i> Wears glasses? Y or N Wears contacts? Y or N
_____ <i>ADD or ADHD Diagnosed:</i> What medications are taken? _____ Will medication be needed in school? Y or N When? _____
_____ <i>Bone/Joint problem or fractures:</i> Which bone or joint? _____ Is a brace worn? Y or N
_____ <i>Seizures:</i> What type? _____ Date of last seizure _____ Medications taken: _____
_____ <i>Episode of loss of consciousness:</i> When? _____ Special treatment? _____
_____ <i>Emotional concerns:</i>
_____ <i>Medications taken at home:</i>
List any other recurrent medical problem or illness you would like the school to be aware of.

Name of student's doctor _____ Phone: _____

Does your child see a specialist? Y or N Name _____
 Phone _____

*Please contact school personnel for medication forms if your child needs medication at school, including inhalers for asthma or epipen for severe allergic reactions. Your child may carry an inhaler if medically authorized and developmentally appropriate, **after** informing school personnel.*

Student health information within the school is limited to the information necessary to serve the student's educational and health interests. Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans.

Parent/guardian signature _____ Date _____

Phone Number _____ Cell Number _____ Work Number _____