**Calhoun County Public Health Department School Wellness Program**

**Student Health Information**

**2017-2018 School Year**

**Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

*Last First Middle Initial* **Male  Female**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Street City Zip*

**Race** White/Caucasian Black/African American Native American Asian Other/Multiple

**Ethnicity** Non-Arabic/Non-Hispanic Hispanic Arabic Native American Other

**Does student have health insurance?** Medicaid Private None

If None, would you like information on Healthy Kids, MI Child, Calhoun County Health Plan? Yes No

**Doctor’s Name & Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentist’s Name & Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does Student Have Any Of The Following:**

|  |  |  |
| --- | --- | --- |
| Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Emergency Treatment Needed  Yes  No | Treatment  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Emergency Treatment Needed  Yes No | Emergency Plan and Medication at School  Yes  No |
| Sting Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Emergency Treatment Needed  Yes No | Emergency Plan and Medication at School  Yes  No |
| Asthma Triggered by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Inhaler Yes No  Nebulizer Yes No | Emergency Plan and Medication at School  Yes No |
| Diabetes  Desired Blood Sugar Range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Uses Insulin Yes No | Emergency Plan and Medication at School  Yes  No |
| Epilepsy/Seizure Disorder Last Seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_  Describe Seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medication Yes No | Emergency Plan at School  Yes  No |
| Heart Condition  Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medication Yes No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Restrictions  Yes  No |

**List any serious illnesses, surgeries, injuries or concussion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Eyes** | Glasses | Contact Lenses | Other |
| **Ears** | Tubes | Frequent Infections | Hearing Aid Difficulty Hearing (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Other (check those that apply)** | | Blood/Bleeding Disorder | | Mental Health Issues | | |
|  | ADD/ADHD | Dental Problems | | Nosebleeds | | |
|  | Birth Defects | Eating Disorder | | Skin Problems | | |
|  | Bladder/Bowel Problems  Blood Pressure Problem | Headaches  Menstruation Problems | | Sleeping Problems  Special Education | | |
| **Describe anything checked above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **What medications are taken regularly?** | | |  | |  | |
| Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| ***Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | | | ***Date:\_\_\_\_\_\_\_\_\_*** | |  | |
| **OVER (COMPLETE BOTH PAGES OF THIS FORM)** | | | | | |

**Calhoun County Public Health Department School Wellness Program**

**Consent for Treatment**

**2017-2018 School Year**

**Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

I give my permission for my child to receive health screenings, BMI measurement/data collection, and health education with pre/post survey, basic health care treatment, and emergency care. In addition, the school nurse may administer any of the medications listed below in accordance with established protocols developed by the Calhoun County Public Health Department School Wellness Program.

|  |  |
| --- | --- |
| * OTC Antibiotic Ointment | * Chewable Antacid Tablets (Tums) age appropriate |
| * OTC Antihistamine Cream * Anti-Fungal Topical Cream * Eucerin Lotion (for Dry Skin) | * Caladryl/Calamine Lotion * OTC Hydrocortisone 1% Cream * Silver Sulfadiazine 1% Cream (Silvadene for burns) |
| * Acetaminophen (Tylenol) | * OTC Oral Diphenhydramine HCL (Benadryl for allergic reaction) |
| * Ibuprofen (Advil) * OTC Oral Loratadine (Antihistamine) * Cough Drops/Throat Lozenges * Orajel for tooth pain | * Sterile Wash for Skin & Eyes * Saline Eye Drops (Non-medicated) * Insta Glucose |

* I understand that All Medications to be administered by school staff or are self-carried by the student require the **Medication Administration Authorization Form** to be completed by the Parent & Physicianprior to administration. ALL medications must be in the original, properly labeled container & dispensed by a physician/pharmacist, or be in the original over the counter packaging.
* I have been given or have had the opportunity to review the CCPHD Privacy Notice, and may have a copy upon request.
* I verify that I am authorized to sign consent for the person named in this document.
* I further consent to release of information to my child’s primary/specialist care provider, and school personnel regarding follow-up care for assessment/treatment provided, coordination of care or school services.
* I understand that I may withdraw my consent at any time during the school year by contacting the health office.

**Parent/Guardian Name (*please print):***

**Parent/Guardian Signature: Date:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Mother/Guardian** | | | |
|  | Home # | Work # | Cell # |
| **Father/Guardian** | | | |
|  | Home # | Work # | Cell # |

**EMERGENCY CONTACT INFORMATION – This must be completed with someone other than parent above.**

**Name (print): Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* The Calhoun County Public Health Department has occasion to use photographs of students and school nurses in our presentations to promote our School Wellness Program to community members and funding partners. Photographs may be used in brochures, posters, newspaper articles, power point presentations, and as part of our annual report to the school community. I grant Calhoun County Public Health Department and it respective agents, employees, officers, and representatives the right, but not the obligation to incorporate or use still photograph(s) in any manner the county sees fit.

*Yes, I give consent for photos Initial\_\_\_\_\_\_\_\_\_\_\_\_ No, I don’t give consent for photos Initial\_\_\_\_\_\_\_\_\_\_\_\_\_*

**\**THIS CONSENT WILL BE IN EFFECT FOR THE 2016-2017 SCHOOL YEAR***

**OVER (COMPLETE BOTH PAGES OF THIS FORM)**