Clear Form

Student Health Information

Teacher_____ **Grade**_____

Student Name _____ **Birth Date** _____/_____/_____
Last *First* *Middle Initial*
☐ **Male** ☐ **Female**
☐ **Transgender** ☐ **Non-Binary**

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

Does student have a doctor that they see regularly? ☐ Yes ☐ No

Doctor's Name & Phone_____ **Date of Last Physical**_____

Does Student Have Any of The Following:

Medication Allergies: _____	Emergency Treatment Needed ☐ Yes ☐ No	Treatment
Seasonal 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)

☐ ADD/ADHD
☐ Birth Defects
☐ Bladder/Bowel Problems
☐ Blood Pressure Problem
☐ Blood/Bleeding Disorder
☐ Dental Problems
☐ Eating Disorder
☐ Headaches
☐ Menstruation Problems
☐ Mental Health Issues
☐ Nosebleeds
☐ Skin 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:_____

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

OVER (COMPLETE BOTH PAGES OF THIS FORM)

Calhoun County Public Health Department School Wellness Program
Consent for Treatment

Student Name_____**Birthdate**_____/_____/_____

I give my permission for my child to receive health screenings, basic health care treatment, and emergency care. In addition, the school nurse may administer over-the-counter medications including but not limited to ibuprofen, acetaminophen, and loratadine in accordance with established protocols developed by the Calhoun County Public Health Department School Wellness Program (SWP). Vaccination and testing for COVID-19 are not covered in this consent. If recommended, a separate consent will be required.

I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed on a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to blood or body fluids.

I have been given or have had the opportunity to review the CCPHD Privacy Notice (located at https://www.calhouncountymi.gov/government/health_department/school_wellness/ and may also be provided a copy upon request.

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 & Physician prior to administration. ALL medications must be in the original, properly labeled container, and dispensed by a physician/pharmacist, or be in the original over-the-counter packaging.

I further consent to the 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.

For Parents/Guardians – I give consent for my student to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I will update the student health information annually as warranted by changes in medical condition. I understand that I may withdraw my consent at any time during the school year by contacting the health office.

I verify that I am authorized to sign consent for the person named in this document.

Parent/Guardian Name (*print*):_____

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

Parent/Guardian _____ _____ _____
Home# Work# Cell#

Parent/Guardian _____ _____ _____
Home# Work# Cell#

Consent to Receive Text Messages Regarding Student: ☐ *Yes, I give consent* ☐ *No, I do not give consent*

EMERGENCY CONTACT INFORMATION: This must be completed by someone other than parent/guardian above.

Name (*print*): _____ **Relationship to Child:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

- Subject or subject's parent/guardian grants Calhoun County, Calhoun County Public Health Department, and its respective agents, employees, officers, and representatives the right, but not the obligation, to incorporate or use still photographs videos, digital images, video, artwork, writings, audiotapes, internet applications, and any other similar media in any manner the County sees fit. This may include promotion of the School Wellness Program.

☐ *Yes, I give consent for photos* *Initial*_____ ☐ *No, I don't give consent* *Initial*_____

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