Unionville-Sebewaing Area Schools
Student Health Form
in conjunction with **Scheurer Health**

Parent/Guardian Consent

I give consent for my child to receive services at Unionville-Sebewaing Area Schools Wellness Clinic provided in conjunction with Scheurer Health. By signing this consent, I certify that I am the legal guardian and legal custodian of the student listed below. This consent will be considered active for the entire school year, unless I withdraw my consent in writing. I understand I may withdraw my consent for service upon written notice to USA Public School's Wellness Clinic at any time. If the clinic does NOT receive the signed consent, staff will not provide any services to your student, unless emergency care/crisis intervention is required. (See below).

PLEASE NOTE: PARENTAL CONSENT IS NOT REQUIRED FOR CRISIS INTERVENTION OR EMERGENCY CARE. EMERGENCY CARE/CRISIS INTERVENTION WILL BE PROVIDED, WITH PARENTAL NOTIFICATION TO FOLLOW.

I further authorize the USA School's Wellness Clinic to release information regarding treatment to other medical or mental health providers when needed for coordination of care. I authorize USA School's Wellness Clinic and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care. I understand that USA School's Wellness Clinic participates in and recognizes the rules of the Health Information Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI).

2023-2024 School Year

Student Name: _____

Parent/Guardian Signature: _____

Unionville-Sebewaing Area School
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Student Health History

To be completed by parent/guardian:

Student Last Name:		**First Name:**		
Date of Birth:	Age:	Male o Female o	Grade:	
Street/Mailing Address, City, Zip Code:				

Parent/Guardian Last Name:	**First Name:**	Relationship to Student:
Home Phone #	Cell #	Work #
Parent/Guardian Last Name:	**First Name:**	Relationship to Student:
Home Phone #	Cell #	Work #
Name of Emergency Contact:	Relationship to Student:	Phone #:
Pharmacy Preference:	Pharmacy Location:	Pharmacy Phone #:
Please select your preferred method of contact: o Phone Call Primary:_____ Secondary:_____ oText o Written Communication o email _____		
Name of Student's Family Dr./NP/PA:		
Date of Student's Last Well Child Exam:	Date of Student's Last Sports Physical:	

Condition	Yes	Condition:	Yes	Condition	Yes
ADD/ADHD		Epilepsy		Pneumonia	
Allergies		Fainting		Seizures/Epilepsy	
Anemia		Frequent Urination		Shortness of Breath	
Anxiety/Depression		Heart Problems		Skin Disorder	
Asthma		Headaches/Migraines		Sore Throats	
Bipolar Disorder		High Blood Pressure		Substance Abuse	
Bladder/Bowel Issues		Joint Problems		Vision Problems	
Diabetes		Kidney Disease		**Other Conditions:**	
Eating Disorder		Nosebleeds			
Eczema/rashes		Pounding of Heart			

Please **X** the **YES column** if any of these conditions apply to the student

Indicate any allergies your child has:

Food Allergies:	Medication Allergies:	Environmental Allergies	Other Allergies:

What type of reaction occurs?	Does the student have an **Epi-Pen**?	Has the student used the **Epi-Pen** in the past?

Please indicate surgeries or hospitalizations the student has had:

Surgeries:	**Hospitalizations:**

Please list any other concerns you have regarding your child:

Medications: List any medications the student takes *regularly* or takes as an *emergency medication* (examples: prescriptions, vitamins, OTC medications, insulin, inhalers or epi-pens)

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		

If you want **prescribed** medications given at school, the parent/guardian must:

1. Bring the prescribed medication in, with it being in the original and labeled container
2. Medications will be accounted for and signed with the parent present
3. Medication form must be completed by parent
4. Parent is responsible for knowing the needed time for refill
5. Notification of change of medication
6. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable for damages or injury result directly or indirectly from this authorization**.**

The school clinic may administer based on availability & appropriateness:

Benadryl/Claritin	Antibiotic Cream	Cough Drops
Pepto (liquid/chewable)	Hydrocortisone Cream	Bactine
Motrin (Ibuprofen)	Anti-itch spray/cream	Thera Tears (eye lubricant)
Tylenol (Acetaminophen)	Anbesol/Orajel	Antacid (TUMS)
Icy Hot (Bio-freeze)	Aloe Vera	Guaifenesin/Tussin (cough expectorant)

Please check only one:

o I **give permission** for my child to take the above medications if indicated per standard clinic treatments.

o Scheurer Wellness Clinic or USA School Personnel **DOES NOT** have my permission to give any medications to my child.

Sign:

Parent/Guardian Signature: _____Date: _____