Searcy Public Schools Health History Form

*Please complete **BOTH SIDES** of this form* _____ School Year

_____ _____ _____
Student's Last Name First Middle Birthdate Grade

_____
Parent Name(s) Address City/Zip Code

_____
Home Phone Cell phone Work phone

_____
Doctor Phone # Dentist Phone #

PERSON(S) TO BE NOTIFIED OF EMERGENCY OR ILLNESS IF PARENT/GUARDIAN CANNOT BE REACHED

NAME	RELATION	HOME PHONE #	CELL PHONE #
1.			
2.			
3.			

The following NON-PRESCRIPTION medications are available in the nurses office; Acetaminophen (Tylenol), Tums, & topicals (triple antibiotic & hydrocortisone). I understand that the school nurse (or trained staff) will determine if the medication is needed, and will administer the age/weight appropriate dose. Generic forms of the medications may be used. I understand that unexpected adverse reactions may occur from any medication, and hereby release the Searcy School District and its employees from any liability related to such unexpected reactions.

***As a general rule these medications are not given before 10:00 a.m. or after 2:00 p.m. to reduce the possibility of over- medicating any student.** All over-the-counter (OTC) non-prescription medications are available to students on a limited basis. Students who require frequent doses of these OTC meds must bring their own supply, and a parent must come in to discuss the use of OTC medications.

Benadryl is given ONLY in cases of acute allergic reactions – no other OTC allergy medications are provided by the school.

☐ **YES**, My child **may** have medication given at school **Parent Signature:**

☐**No**, My child **may not** have any medication given at school _____

In the event of a medical emergency and an ambulance is called, EMS will determine the appropriate care.

INSURANCE

☐ Private Insurance _____Policy # _____Phone #_____

☐ AR Kids / Medicaid #_____

☐ No insurance

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid. In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)

I, _____, give permission for my child, _____'s
(Parent/Guardian Name) (First and Last Name)
personally identifiable information/student education records to be disclosed to

_____for the purpose of billing Medicaid and/or private insurance.
(Name of Third Party)

_____ _____ _____
Printed name of Parent/Guardian Parent/Guardian Signature Date Signed

⇨

Health History

Student Name:_____

Please check "Yes" or "No" on all health concerns. If you answer "yes", please answer the questions associated with that health concern.

****(Please ask your doctor to provide written orders for management of this medical condition at school.)***

Yes	No	Health Concern	Description
		ADD/ADHD*	Medication required?_____ Name of medication:_____ Given at school? Doctor's name/Phone:
		ASTHMA* (Diagnosed by a doctor)	Medication/inhaler? _____ Daily? _____ As needed? _____ With exercise? _____ Name of medication:_____ In nurse's office? _____ Student carries/administers inhaler? _____ How often seen by doctor? Last ER visit due to asthma?
		ALLERGIC REACTION	To what? _____ Hives/Rash? Yes___ No___ Breathing difficulty? Yes___ No___ Other? _____ Has EpiPen? Yes___ No___ Where is EpiPen kept? Nurse's Office ___ Carries own ___ Doctor's Name/Phone:
		BONE/JOINT PROBLEMS	Any physical limitations? _____ History of broken bones? _____ Osgood–Schlatter disease? Arthritis? Other?
		DEPRESSION	Medication required? Yes___ No___ Given at school? Yes___ No___ Name of medication:
		DIABETES*	Type I____Type II____ Medications? Oral_____ Injection_____ Pump_____ Doctor's Name/Phone:
		EAR PROBLEMS	Frequent infections? Past___ Present___ Tubes? Past____ Present____ Permanent hearing loss? Hearing Aid?
		HEART PROBLEMS*	Diagnosis: _____ Physical restrictions? Yes___ No___ Medications? Yes___ No___ At Home? ____ At school? _____ Name of medication:
		HYPERTENSION	Medication required? Yes___ No___ What time is medication given? _____ Name of medication:
		FREQUENT HEADACHES MIGRAINE HEADACHES*	Frequency?_____ Known Triggers:_____ Best Treatment?
		SEIZURE DISORDER*	Frequency of seizures? _____ Date of last seizure? _____ Name of medication:
		VISION	Wears glasses? _____ Contacts? _____ Reading only? _____ All the time? _____ Date of last exam? _____ Doctor's Name/Phone:
		OTHER HEALTH CONCERNS?* (Cystic Fibrosis, Celiac Disease, Hemophilia, etc.)	Diagnosis:_____ Medications: _____ Doctor's name/phone: