CONFIDENTIAL SCHOOL HEALTH HISTORY/CONSENT FORM

Student's Last Name: _____ First: _____

Race: _____ Sex: _____ Age: _____

School: _____ Teacher: _____ Grade: _____

Mother/Guardian: _____	Father: _____
Home Phone # _____ Work Phone # _____	Home Phone # _____ Work Phone # _____
Home Address: _____	Home Address: _____
Mailing Address: _____	Mailing Address: _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Pager: _____ Cellular Phone _____	Pager: _____ Cellular Phone _____

*Emergency Contact Name & Phone Number (Other than Parent):

Does your child have medical problems or receive any treatment for medical problems? ☐ Yes ☐ No

If yes, please explain:

Does your child take any medicine every day? ***If yes, please explain:*** ☐ Yes ☐ No

Name of Medications: _____ Dosage/Strength: _____ How many times a day given: _____

Has your child had surgery or been hospitalized? ☐ Yes ☐ No

If yes, please explain:

Has your child ever had any of the following medical problems? Check all answers that apply.

Asthma		Fainting spells		Orthopedic problems (bone or joint)	
Low Iron in blood		Heart problems		Sickle Cell Disease (not trait)	
Cancer		Hemophilia (bleeding problems)		Tuberculosis	
Diabetes		Lead poisoning (lead in the blood)		Urinary problems (kidney or bladder)	
Epilepsy (fits or seizures)		Meningitis		Hernia	
Bone/muscle problems (pain, trouble walking)		Neurological problems (brain or spinal cord)		Other (explain):	

Is your child allergic to or unable to take any medication (prescription or over the counter)? Please list the name and type of reaction they have had.

	Medicine(s):
	Food(s):
	Bee or other insect(s):

Does your child have any of the following problems? Check all answers that apply.

Frequent headaches		Nerves (clumsy, poor balance)		Emotional/Behavorial Problems	
Frequent illnesses		Shortness of breath		Bed Wetting	
Frequent ear infections		Vision problems		Wears glasses	
Dental problems (toothaches, cavities)		Hearing problems		Wears hearing aid	
Skin problems		Learning problems		Other (explain):	

If yes, please explain:

What is your child's Doctor's Name?	Date of last visit & why?
What is your child's Dentist's Name?	Date of last visit & why?

*What is your child's payment source for medical care?

☐ Medicaid Number _____ ☐ Private Insurance _____ (Name & Company) ☐ None

PERMISSION FOR SERVICES

I give my permission for my child to receive medication or medical treatment or age appropriate school health screenings. Prescription medications may be given at the school with a signed prescription and properly labeled container from the pharmacist.

In the case of emergency and I cannot be reached, I would like my child transported to the nearest emergency room by Emergency Medical Services (EMS). I understand that I am responsible for all expenses associated with the emergency.

I understand that information about my child will be shared on a "need to know" basis within the school and the school will also share information with the S.C. Department of Health and Environmental Control (DHEC) and other pertinent health employees.

I understand that 1) chronic illness or chronic medication regimens require individualized health plans to be developed with the parent and school nurse and approved by my child's physician and 2) if my child is to self-medicate then the self-medicating board policies must be followed.

I, parent/guardian, will not hold the school, Orangeburg Consolidated School District Five, or district personnel liable for the effect of medication upon the student.

If applicable, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on behalf of Orangeburg Consolidated School District Five (OCSDS) for any services provided to my child. Permission is also granted to OCSDS to exchange medical or other confidential information as necessary to the health care financing administration, its agents or other agents needed to determine these benefits for related services.

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_____ Student's SS#: _____

PARENT/GUARDIAN SIGNATURE **DATE** Student's DOB: _____