SCUC Independent School District - Health Services Student Emergency Information/Health History

Student's Name: Last	**First**	**M.I.**	**Student ID#**
Grade ☐Male ☐Female	Birthdate		
Home Address – Street, City, Zip		Home Phone Number	

Parent/Guardian Name	Email Address	Cell Number	Work Number
Parent/Guardian Name	Email Address	Cell Number	Work Number

Please list Persons who will assume temporary care of <u>AND / OR</u> pick up your child if you cannot be reached:

Name	Cell Number	Work Number	Relationship to Student
Name	Cell Number	Work Number	Relationship to Student

In an effort to provide safe, informed care for your child at school, each year the SCUCISD Health Services Department requires the following information to complete your child's enrollment. Medical Information you provide about your child is a confidential education record. SCUCISD keeps all medical information about your child confidential as required by the Family Educational Rights and Privacy Act and other applicable laws. However, health information about your child will be communicated to SCUCISD school personnel who require the information to better serve your child.

Health History: Check all health conditions that apply

☐ **Student has a 504 PLAN for health related accomodations**

☐ **ADHD/ADD** ☐ Medications taken at home ☐ Medications taken at school ***DOCTOR ORDER REQUIRED (See Nurse)***

☐ **ALLERGIES** ***(Specify & describe below):*** ☐ Drug ☐ Food ☐ Insect

☐ DRUG - Drug(s) & Reaction_____

☐ STUDENT REQUIRES EPIPEN and / or BENADRYL AT SCHOOL ***DOCTOR ORDER REQUIRED (See Nurse)***

☐ FOOD - List Food(s) & Reaction_____

FOOD ALLERGY ACTION PLAN FROM DOCTOR REQUIRED FOR SEVERE FOOD ALLERGIES (See Nurse)

☐ Insect – List Insect(s) & Reaction: _____

☐ **ASTHMA** ***ASTHMA ACTION PLAN FROM DOCTOR REQUIRED FOR INHALERS / NEBULIZERS TO BE GIVEN AT SCHOOL (See Nurse)***

☐ **DIABETES** ***(Specify):*** ☐ Type 1 ☐ Type 2

DIABETIC MANAGEMENT PLAN FROM DOCTOR REQUIRED FOR TYPE 1 DIABETES (See Nurse)

☐ **EMOTIONAL/PSYCHOLOGICAL DISORDER** Specify: _____

☐ **HEARING PROBLEMS :** ☐ Hearing Aid ☐ Cochlear Implant Other: _____

☐ **HEART CONDITION** ☐ Heart Defect ☐ High Blood Pressure ☐ Other:_____

☐ **KIDNEY/URINARY PROBLEMS** Explain: _____

☐ **MEDICATION(S) TAKEN AT HOME/SCHOOL:** _____

****** ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A WRITTEN ORDER FROM YOUR CHILD'S DOCTOR EVERY SCHOOL YEAR (See Nurse)******

☐ **MIGRAINES/HEADACHES** Explain: _____

☐ **SEIZURE DISORDER** ***SEIZURE ACTION PLAN FROM DOCTOR REQUIRED (See Nurse)***

Date of last seizure_____ Type of seizures_____

☐ **STOMACH / INSTESTINAL PROBLEMS** Explain: _____

☐ **VISION PROBLEMS:** ☐ Wears glasses ☐ Contact Lenses ☐ Other: _____

☐ **SPECIAL PROCEDURE(S) AT SCHOOL** ***DOCTOR ORDER REQUIRED (See Nurse)***: _____

☐ **OTHER HEALTH CONCERNS:** _____

☐ ***MY CHILD HAS NO HEALTH CONDITIONS AND WILL NOT REQUIRE MEDICATION / SPECIAL PROCEDURES AT SCHOOL***

I, the undersigned, do hereby authorize officials of Schertz-Cibolo-Universal City Independent School District to contact directly the persons named on this form in case of emergency for said child. In the event parents or other persons named on this form cannot be contacted, school officials are hereby authorized to take whatever actions are deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Date: _____ Signature of Parent/Guardian: _____