



Health Information

Student's Name _____ Grade _____ DOB ____/____/____

Doctor's Name:	Phone:
Dentist's Name:	Phone:
Allergist's Name:	Phone:
Eye Care Provider:	Phone:
Other Healthcare provider:	Phone:

HIPAA LAW

Due to recent changes in confidentiality laws, it is difficult to exchange needed information with Health Care Providers. For this reason, we would ask that you complete and sign the release below. Information requested may include, but not be limited to, immunization records, physical forms, medication authorization, and restriction or release or activity information. Your physician may also request that you sign a similar release.

I authorize the exchange of pertinent medical and/or psychological information between the physician and the school nurse for my children listed below:

Student Name(s):	_____ _____ _____
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Sign Here

_____ Date

Parent/Guardian Signature

Relationship to student: Mother Father other: _____

In case of Emergency

I understand the final disposition of an emergency case, the judgement of the school authorities will prevail. Anytime this information must be changed, I will notify the nurse in writing.

Sign Here

_____ Parent/Guardian Signature

Parent/Guardian Signature

Parent/Guardian Signature

Relationship to student: Mother Father other: _____



Student Medical History Information

To be completed by Parent/Guardian.

Student's Name _____ Grade _____ DOB ____/____/_____

Has your child had any of the conditions listed below?
Please check those conditions that apply and give month and year if known.
Provide additional information below if necessary.

- | | | |
|--------------------------------|-----------------------------------|-----------------------------|
| _____ Asthma | _____ Kidney Disease | _____ Serious Head Injuries |
| _____ Bladder Infection | _____ "Lazy Eye" | _____ Chicken Pox |
| _____ Congenital Heart Disease | _____ Loss of Consciousness | _____ Dislocations |
| _____ Cystic Fibrosis | _____ Other Eye Problems | _____ Hospitalization |
| _____ Diabetes | _____ Pneumonia | _____ Menstrual Cycle |
| _____ Ear Infections | _____ Undescended or One Testicle | _____ Mononucleosis |
| _____ Enuresis (Bed Wetting) | | _____ Operations |
| _____ Fractures | _____ Allergies | _____ Orthopedic Problems |
| _____ Frequent Sore Throat | _____ Foods | _____ Seizure Disorder |
| _____ Glasses or Contact Lens | _____ Hay Fever | _____ Serious Injuries |
| _____ Hearing Loss | _____ Drugs | _____ Skin Conditions |
| _____ Heart Murmur | _____ Bee Stings | _____ Speech Concerns |
| _____ Hepatitis | _____ Require epinephrine? | _____ Other |
| _____ Hernia __ Repaired _____ | | |

Medications: Is your child currently taking medications? _____
Name of medication(s) _____
Reason medication(s) is being taken _____

Has anyone in your family died of Heart Disease or Sudden Death before the age of 50? _____

Does your child have any emotional problems that we should be aware of? _____
Please explain: _____

May your child have a physical at school? Yes No

If your child has had a physical exam in the last 12 months, please fax a copy to your child's school building Nurse. (See fax numbers below)



Parent/Guardian Name Print: _____ Signature: _____ Date: _____

Relationship to student: Mother Father other: _____

Morrisonville Elementary
Sabrina Paine 565-5923
Fax 565-5972

Saranac Elementary
Emily Brown 565-5844
Fax 565-5890

Saranac Middle School
Sarah Sorensen 565-5650
Fax 565-5706

Saranac High School
Lynda Tripp 565-5806
Fax 565-5809