Saranac Central School District
P.O. Box 8, Saranac, New York 12981

Yearly Update

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):	_____ _____ _____

Sign Here _____ _____
Parent/Guardian Signature Date

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

Relationship to student: ☐ Mother ☐ Father ☐ other: _____

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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
_____Bladder Infection
_____Congenital Heart Disease
_____Cystic Fibrosis
_____Diabetes
_____Ear Infections
_____Enuresis (Bed Wetting)
_____Fractures
_____Frequent Sore Throat
_____Glasses or Contact Lens
_____Hearing Loss
_____Heart Murmur
_____Hepatitis
_____Hernia __Repaired _____

_____Kidney Disease
_____"Lazy Eye"
_____Loss of Consciousness
_____Other Eye Problems
_____Pneumonia
_____Undescended or One Testicle

_____Allergies
_____Foods
_____Hay Fever
_____Drugs
_____Bee Stings
_____Require epinephrine?

_____Serious Head Injuries
_____Chicken Pox
_____Dislocations
_____Hospitalization
_____Menstrual Cycle
_____Mononucleosis
_____Operations
_____Orthopedic Problems
_____Seizure Disorder
_____Serious Injuries
_____Skin Conditions
_____Speech Concerns
_____Other

_____

_____

_____

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)

Sign Here **Parent/Guardian Name Print: _____Signature: _____ Date: _____**

Relationship to student: ☐ Mother ☐ Father ☐ other: _____

Morrisonville Elementary	**Saranac Elementary**	**Saranac Middle School**	**Saranac High School**
Martha Smith 565-5923	Emily Brown 565-5844	Sarah Hart 565-5650	Lynda Tripp 565-5806
Fax 565-5972	Fax 565-5890	Fax 565-5706	Fax 565-5809