FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT
Health History of Student with _____

Student: _____ DOB_____ Teacher: _____ Grade: _____
School: _____Parent/Guardian & Phone(s): _____
Physician & Phone: _____ School Year: _____

KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records and information indicates your child has _____(condition). In order to attend to your child's health and safety, the school needs a health history. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while attending school.

_____ _____ _____
School Nurse Phone number Date

1. When was your child diagnosed? _____
2. When was your child last seen by a doctor? _____
3. What doctor(s) (include phone numbers) does your child see for this? _____
_____
4. Has your child ever been hospitalized for this? ☐ No ☐ Yes If yes, when? _____
5. Describe your child's usual symptoms when condition needs attention: _____
6. How have you treated these symptoms? _____
7. Please list the medications your child takes for this condition:

Name of Medication	Dosage	Time

8. List any other medications your child takes?

Name of Medication	Dosage	Time

If medications must be given during school hours, an **Authorization for Medication** form must be completed every school year. It must be filled out and signed by you and your physician. Medications used in school must be in the original container. When you have a prescription filled, ask the pharmacist for two containers; one for school and one for home use. If your student participates in field trips and needs medication during that time, a separate container may be necessary for that day as well.

CONSENT

(I do /I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if School Nurse determines that this information is necessary to assure my child's health and safety.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
ROLES & RESPONSIBILITIES
_____(Health Condition)

Student: _____ DOB: _____ Teacher: _____ Grade: _____
Parent/Guardian & Phone(s): _____ School Year: _____

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or School Administration Designee Date

_____ _____
School Nurse Date