Florida Department of Health in Miami-Dade County
School Health Program
Health History and Consent: Cystic Fibrosis

Student: _____ DOB: _____ Grade: _____
School: _____ School Year: _____Teacher: _____
Parent/Guardian Name & Phone: _____
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has diabetes. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. 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 in school.

_____ _____ _____
School Nurse Phone number Date

1. When did your child last see a doctor related to this condition? _____

2. Has your child ever been hospitalized for cystic fibrosis? ☐ Yes ☐ No If Yes, when? _____

3. Does your child have any other medical conditions? ☐ Yes ☐ No If Yes, explain: _____
_____

4. Please list all medications your child takes below.

Name of Medication	Dosage	Time Given	How often?

5. What symptoms does your child experience? _____
_____

6. Does your child require a diet modification? ☐ Yes ☐ No If Yes, explain _____
_____

7. Additional comments:
_____
_____
_____

CONSENT:

Please circle your response and sign: **(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 sharing of this information is necessary to promote my child's health and safety.

Parent/Guardian Signature: _____ Date: _____