



**Florida Department of Health in Miami-Dade County  
School Health Program  
Health History and Consent: \_\_\_\_\_**

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.

\_\_\_\_\_ Phone number \_\_\_\_\_ Date \_\_\_\_\_  
 School Nurse

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 (FM-2702E)** form must be completed every school year. It must be completed and signed by you and the student's healthcare provider. 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**

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: \_\_\_\_\_