

SEGUIN INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

School Year: _____ / _____	STUDENT HEALTH HISTORY	ID #: _____
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Student: _____ DOB: _____ Grade: _____ Sex: M / F
Address: _____ City: _____ Zip: _____
Mother: _____ Cell: _____ Work: _____
Father: _____ Cell: _____ Work: _____

Emergency contacts who can assume responsibility for your child. **MUST COMPLETE THIS INFORMATION WITH TWO CONTACTS.** (Please make sure these are **additional** phone numbers to the ones listed above)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

How is health care provided for this student? Private Insurance _____ Medicaid _____ SSI _____ CHIPS _____ Other _____
Please give the name of your child's health provider(s) / Doctor(s)? _____
Phone number(s) for Doctor(s): _____

CIRCLE BELOW AND COMMENT ON PAST OR CURRENT HEALTH PROBLEM(S) **NO** Health Problems: _____ (PLEASE INITIAL)

Allergies (*please include all medication and food allergies*) _____

ADD/ADHD: _____	Kidney / Bladder: _____
Asthma: _____	Orthopedic: _____
Blood Pressure: _____	Respiratory: _____
Dental: _____	Serious illness/injury: _____
Diabetes: _____	Special Diet: _____
Head Injury: _____	Surgeries: _____
Hearing / Hearing Aid: _____	Vision: _____ glasses _____ contacts _____ reading only
Heart / Murmurs: _____	Other: _____

Seizures / date of last seizure: _____

- PLEASE LIST ALL MEDICATIONS: Daily meds: _____
- Meds to be taken at school (**meds provided by parent**): _____

Has your child been hospitalized for a major illness? If yes, please explain: _____

Is your child currently under medical care? Yes _____ No _____ If yes, please explain: _____

Is there anything we need to know about your child's health? Yes _____ No _____ If yes, please explain: _____

I authorize officials of Seguin ISD to contact persons named on this form or on the enrollment card and authorize the physician or emergency room personnel to render treatment of this child as may be necessary in an emergency. If I or the designated persons I have listed are not available, I authorize the officials of Seguin ISD to take whatever action is deemed necessary in their judgment for the health of my child.

I understand that we as parents or guardians are responsible for providing transportation in case of our child's illness or accident, including costs of an EMS ambulance if necessary. I am aware that school officials may have to arrange transportation for our child in a serious situation.

I authorize for the physician/health care provider(s) named on this card to be contacted for the pertinent health information to be received and given on my child.

Parent/Guardian Signature: _____ Date: _____