

My School's Health Center Consent Form

Down the hall, and here to help.

THE MEDICAL INFORMATION ON THIS FORM MAY BE USED TO UPDATE YOUR STUDENT'S SCHOOL HEALTH RECORD. POTENTIALLY LIFE THREATENING HEALTH CONDITIONS (I.E. BEE STINGS, ALLERGIES) MAY BE SHARED WITH STAFF.

Student Name:							
Last	First	M.I.	Date of Birth	Race	Ethnicity	Student Number	
Current Grade: _____		Age: _____		Male	Female	School: _____	
Parent/Guardian Name #1 (please write above)				Parent/Guardian Name #2 (please write above)			
Home Address: (please write above)				Home address: (please write above)			
City	State	Zip (please write above)		City	State	Zip (please write above)	
Hm Phone: _____				Hm Phone: _____			
Cell Phone: _____				Cell Phone: _____			
Wk Phone: _____				Wk Phone: _____			
<p>What type of health insurance does your student have? (please circle one)</p> <p><input checked="" type="checkbox"/> X - I do not have any type of health insurance P - Private Insurance</p> <p><input type="checkbox"/> U - I'm not sure what type of health insurance I have M - Medicaid (OMAP)</p> <p><input type="checkbox"/> O - Oregon Health Plan IN - Indian Health Services</p> <p>Name of Private Insurance: _____ Group # _____</p> <p>Subscriber of Insurance: _____ ID # _____</p> <p>Physician/Doctor: _____ Insurance phone #: _____</p>							
<p>Services will not be withheld for an inability to pay. However, for persons with insurance, some visits may be billable. We will contact you before billing. I give permission for the School District 4J Health Center to bill my insurance company for appropriate services. I also authorize the Health Center to furnish the insurance company with all relevant information if requested.</p>							
Parent/Guardian Signature:				Date:			
<u>Current Medications:</u>				<u>Allergies or Previous Reaction to Medication:</u>			
<u>Chronic Health Conditions (i.e. asthma):</u>				<u>Life Threatening Allergies (i.e. peanut, bee sting):</u>			
<p>I give the health center staff permission to dispense over-the-counter medications (ibuprofen, acetaminophen, decongestants, etc.) to my son/daughter and to medically evaluate (including simple lab tests) and treat my child. I have completely disclosed all known allergies, medications presently in use, and chronic health conditions of my child. In addition, the Health Center has my permission to share my child's immunization records and their most recent physical exam between their 4J School District records and their Health Center medical file.</p>							

I have read and completed this consent. I understand that if I have any questions I may speak to the clinic healthcare provider.

Parent/Guardian signature

Date Patient signature

Date

Student Name: _____ Birthdate: _____ Today's Date: _____

STUDENT HISTORY			FAMILY MEDICAL HISTORY (circle one)			
YES	NO	HAS THE STUDENT HAD ANY:	YES	NO	Has any family member died suddenly at less than 50 years of age causes other than an accident?	
		Chronic or recurrent illness such as diabetes, seizures, hepatitis, mono?				
		Hospitalization/Surgeries?				
		Urinary, kidney problems, undescended testicles?				
		Missing or damaged organs (eye, kidney, testicles?)				
		Problems with heart or blood pressure?				
		Chest pain with exercise? Wheezing? Coughing?				
		Dizziness or fainting with or without exercise?				
		Frequent headaches, anemia, bleeding, or blood clot problems?				
		Learning disorders or slowed development?				
		Vision or hearing problems?				
		Problems with substance abuse?				
		Problems with depression?				
		Problems with anxiety?				
		DOES THIS STUDENT				
		Wear eyeglasses or contact lenses?				
		Wear dental bridges, braces, plates?				
		Take any medication on a regular basis? (prescription or over the counter)				
		IS THERE A HISTORY OF:				
		Concussion, loss of consciousness, convulsions?				
		Injuries to neck, knees, ankles?				
		Broken bones, joint injury, disease or dislocation?				
		HAS STUDENT HAD:				
		Chicken pox? If so, what yr?				
		2nd MMR (measles, mumps, rubella?)				
		Hepatitis B Vaccine series?				
		Year of last Tetanus vaccine?				
DATE OF LAST DENTAL EXAM?			DATE OF LAST PHYSICAL?			

USE THIS SPACE TO EXPLAIN ANY YES ANSWERS OR TO PROVIDE ADDITIONAL INFORMATION.

Churchill High School
 1850 Bailey Hill Road
 Eugene, OR 97405-1199
 Office (541) 790-5227
 Fax (541) 790-5229

South Eugene High School
 400 East 19th Avenue
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 Office (541) 790-8020
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North Eugene High School
 200 Silver Lane
 Eugene, OR 97404-2299
 Office (541) 790-4445
 Fax (541) 790-4446

Sheldon High School
 2455 Willakenzie Road
 Eugene, OR 97401-4898
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