Brunswick School Department

HEALTH Questionnaire and Consent Form (printed on back)

Student's Name _____DOB_____Grade _____

Mother's Name_____phone number_____

Father's Name_____phone number_____

Primary Care Physician_____Dentist_____

Name and State of Last school attended_____

PLEASE CHECK ALL THAT APPLIES TO YOUR CHILD

☐ADHD ☐Hearing ☐Scoliosis

☐Headaches ☐Heart Condition ☐Vision

☐Diabetes ☐ Mental Health

☐Allergies Explain _____

Epi-Pen prescribed: Yes____ No____ **If Yes**, please provide **Allergy Action Plan**

☐Asthma

Inhaler Prescribed: Yes_____ No_____ **If Yes**, please provide **Asthma Plan**

☐Seizures Explain_____ (Please provide **Seizure Plan**)

☐ Other chronic Health concerns (specify) _____

IN THE PAST YEAR, HAS YOUR CHILD… (Please explain all yes responses below)

had any serious illness? Yes_____ No_____

had any serious injuries? Yes_____ No_____

had mental health problems? Yes_____ No_____

been hospitalized? Yes_____ No_____

had surgery? Yes_____ No_____

Does your child have any restrictions? Yes_____ No_____

Comments:_____

_____

LIST ALL MEDICATION TAKEN BY YOUR CHILD

At Home_____

At School_____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.

_____ _____

Parent/Guardian Signature Date

rev.1/2017

Brunswick School Department Health Consent Form

Consent to Allow Verbal Communication
Regarding Your Child's Health Care with Their Health Care Provider

Child's Name_____ Date of Birth_____

By signing below I am allowing the School Nurse to discuss certain pieces of my health information with the specific individual(s) of my choosing listed below:

Provider's authorized to discuss my child's Health Care
Name:_____ Phone:_____

Address:_____

Name:_____ Phone:_____

Address:_____

This consent remains in effect until it is revoked in writing or a new consent is executed in its place. This consent may be revoked at any time except to the extent any person has taken action in reliance upon this consent. Revocation must be made in writing to the facility releasing the information.
MEDICAL INFORMATION checked below may be communicated:

☐ Entire Medical Record (excluding sensitive information*)
☐ History and Physical
☐ Diagnostic Reports
☐ Lab/Pathology Reports
☐ Consultation Reports
☐ Immunization Records
☐ Radiology Reports
☐ Hospital Reports
☐ Office Visit Notes

☐ Other:_____

I, as legal guardian of the child named above, hereby consent to the release of the child's protected health information "checked" above.

Signature:_____ Date:_____

***SENSITIVE INFORMATION:**
By checking the (below) boxes and signing below, I DO authorize the release of information considered to be sensitive. This information may include or pertain to treatment and/or diagnosis of HIV status, mental health issues (excluding psychotherapy notes), substance abuse or *"other"* issues. I understand that I have the right to review any mental health information before release of such information.
☐ HIV ☐ Mental Health ☐ Substance Abuse
☐ Other:_____

Signature:_____ Date:_____