16717 Ella Blvd.
Houston, Texas 77090
www.springisd.org

Student Health Information

To be Completed by Parent or Guardian

2017-18

Name of Student _____ Grade _____ Student ID# _____ Date _____

Home Address _____ Date of Birth _____ ☐ M ☐ F Gender

EMERGENCY CONTACTS (PERSONS WHO HAVE PERMISSION TO PICK UP STUDENT OR BRING MEDICATIONS)

Primary Guardian Name: _____ Cell Phone _____

Place of Employment: _____ Work Phone _____ EXT. _____

Secondary Guardian Name: _____ Cell Phone _____

Place of Employment: _____ Work Phone _____ EXT. _____

Others:____ Name: _____ Relationship _____

Home Phone: _____ Work Phone _____ EXT. _____ Cell Phone _____

General Physician _____ Phone _____

Physician Specialist _____ Phone _____

Health Insurance (check all that apply)

☐ CHIP ☐ Medicaid ☐ Harris County Hospital District Medical Card ☐ Private Insurance ☐ None

HEALTH INVENTORY

Students are not allowed to carry medications while at school. No medication will be given at school without written permission.
Refer to the student handbook or school nurse for proper medication procedures and special circumstances.
Medication not picked up at the end of the year will be destroyed.
Students with a fever above 100°F before taking medication should remain at home.

Contact NURSE each year regarding all serious medical conditions

Check YES or NO to the following conditions as they apply to your child.
Chronic medical conditions such as asthma, seizures and diabetes require yearly management plans to be completed.
Explain symptoms, history, and treatment of other health problems in lines below, or on additional pages.

(Check Yes or No for each health concern)

HEALTH CONCERN	YES	NO	HEALTH CONCERN	YES	NO	HEALTH CONCERN	YES	NO
ADD/ADHD (Med Y/N)			Down Syndrome			Orthopedic Problems		
Arthritis- Juvenile			Eating Disorder			Pregnant (Due Date__)		
Asthma (Med at school Y/N)			Headaches- Frequent/Severe			Psychological/Emotional Problems		
Autism			Hearing Loss-Permanent/Aides			Seizures/Convulsions/Epilepsy		
Birth Defects/Congenital			Heart Problems			Sickle Cell Anemia/Trait (Circle 1)		
Blackouts/Fainting			Hemophilia			Stomach Problems		
Bladder Problems			Hypertension/High Blood Pressure			Substance Abuse		
Bowel Problems			Kidney/Renal Problems			TB skin test ever showed Positive		
Cancer/Malignancy			Intellectual Disability			Vision Loss-Permanent		
Cerebral Palsy			Migraines per Dr. Diagnosis			Glasses/Contacts -Last exam		
Cystic Fibrosis			Muscular Dystrophy			Hx of Chicken Pox (Must sign form)		
Diabetes			Nosebleeds-Frequent/Severe			Other Serious Medical Problems	Specify below	

SIGNIFICANT ALLERGIES (Food/Drug/Insect/Other) _____

Symptoms _____ Treatment _____ Epipen ☐ Yes ☐No

List all medications and treatments required AT SCHOOL

_____

_____

List all medications/Vitamins/Herbs/Health Food Supplements and treatments *GIVEN AT HOME*

_____

Additional comments: _____

☐ Y ☐ N I grant permission for my child to receive the routine screening services offered by the Spring Independent School District, which may include: vision, hearing, Acanthosis Nigricans (AN), scoliosis, language, speech and general testing as to mental ability, vocational aptitude, interest inventories, and achievement.

☐ Y ☐ N I give permission for school nurse or nurse program leader to contact the student's physician regarding health needs and authorize staff members to consent to emergency medical treatment. I understand in granting this authorization that:

- My child will be taken to a hospital or clinic nearest to the school or activity he or she is attending so that emergency medical treatment can be obtained.
- School staff members will attempt to contact me before consenting to emergency medical treatment for my child.
- I will be responsible for all expenses incurred by virtue of the emergency medical treatment of my child and for the transportation to the emergency medical treatment facility.
- I release Spring ISD staff members and trustees from any and all claims or actions from liabilities for the injuries that occur to my child as a result of his or her receipt of emergency medical care.
- The staff members of the Spring ISD, its trustees and agents are not waiving any sovereign or governmental immunity by requesting the execution of this document.
- I understand the provisions of this document and execute it voluntarily.

_____ _____

Parent Signature or *Student/Firma del Padre o *Estudiante Date/Fecha