Bloomfield Department of Health **Office of Public Health Nursing** **Non-Public School Health Services**

Student Health History / Health Information Release Authorization

School Year: _____ Grade _____ Date Form Completed _____

Student Name _____ Date of Birth _____ Male / Female

Health Care Provider _____ Phone _____

Student Medical Conditions; List: _____

Student Allergy to Food; Medication; Bee Stings; Latex; Seasonal; Other; List: _____

_____

_____Reaction: _____

Does your child require emergency medication to be kept in school? YES NO Name of med: _____

Student Health History

Please check all that apply:

Condition	Yes	No	Year	Condition	Yes	No	Year
Asthma				Wears glasses or contacts			
Diabetes				Speech difficulty			
Seizures				Hearing difficulty			
ADHD				Frequent urinary infections			
Heart Condition				Frequent throat infections			
Head Injury / Concussion				Frequent ear infections			
Cancer				Frequent colds			
Skin Disease				Frequent headaches			
Tuberculosis				Frequent stomachaches			
Scoliosis				Wets or soils self			
Migraines				Operations:			
Anxiety / Depression							
Gastrointestinal Problems				Fractures:			
Fainting							
Joint / Limb Injury				Other:			

1. Does your child have a medical condition(s) not listed above? Explain_____
2. Does your child take any medication(s) that may need to be given during school hours? List medication: _____
   _____
3. Please explain any concerns regarding your child's behavior or emotional well-being of which the Health Office should be aware of: _____

Health Information Release Authorization

The Family Rights and Privacy Act (FERPA) prohibits the disclosure of a student's health information without the written consent of the student's parent/guardian. In order to comply with this privacy law, the School Nurse(s) is requesting your permission to share medical information about your child only as necessary to protect his/her health and safety while at school. This would include: history of asthma or seizures; allergies that may require the use of emergency medication; or disabilities in hearing, vision or other physical limitations affecting your child at school. This may be done in the form of a printed list or verbal exchange with your child's teacher(s) or school principal. Please note that designated school office personnel provide treatment for students in the absence of the school nurse and may need to be aware of a student's medical condition. As always, please feel comfortable in the knowledge that any information you do not wish to be shared will be kept confidential.

I hereby authorize an exchange of information to occur between School Health Services and (please specify):

_____

_____Regarding any or all information _____ Regarding specific information (please specify on line below):

_____

_____I DO NOT authorize the release/exchange of any of my child's health information

THIS AUTHORIZATION IS IN EFFECT FOR THE SCHOOL YEAR STATED ABOVE. THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Parent/Guardian Name (print): _____ Signature: _____