Saranac Central School District

P.O. Box 8, Saranac, New York 12981

Yearly Update

Health Information

Student's Name ____Grade______ DOB____/______/______

Doctor's Name:	Phone:
Dentist's Name:	Phone:
Allergist's Name:	Phone:
Other Healthcare provider:	Phone:

HIPAA LAW

Due to recent changes in confidentiality laws, it is difficult to exchange needed information with Health Care Providers. For this reason, we would ask that you complete and sign the release below. Information requested may include, but not be limited to, immunization records, physical forms, medication authorization, and restriction or release or activity information. Your physician may also request that you sign a similar release.

I authorize the exchange of pertinent medical and/or psychological information between the physician and the school nurse for my children listed below:

Student Name(s): ______________________________

____

____

Sign Here

____ ____________________

Parent/Guardian Signature Date

Relationship to student: ☐ Mother ☐ Father ☐ other: ____________________

In case of Emergency

I understand the final disposition of an emergency case, the judgement of the school authorities will prevail. Anytime this information must be changed, I will notify the nurse in writing.

Sign Here

______________________________ ______________________________

Parent/Guardian Signature Parent/Guardian Signature

Relationship to student: ☐ Mother ☐ Father ☐ other: ____________________

Turn Over ---->

Student Medical History Information

To be completed by Parent/Guardian.

Student's Name ____ Grade_______ DOB _____/______/__________

Has your child had any of the conditions listed below?
Please check those conditions that apply and give month and year if known.
Provide additional information below if necessary.

____________Asthma
____________Bladder Infection
____________Congenital Heart Disease
____________Cystic Fibrosis
____________Diabetes
____________Ear Infections
____________Enuresis (Bed Wetting)
____________Fractures
____________Frequent Sore Throat
____________Glasses or Contact Lens
____________Hearing Loss
____________Heart Murmur
____________Hepatitis
____________Hernia __Repaired _______

____________Kidney Disease
____________"Lazy Eye"
____________Loss of Consciousness
____________Other Eye Problems
____________Pneumonia
____________Undescended or One Testicle

____________Allergies
______Foods
______Hay Fever
______Drugs
______Bee Stings
____________Require epinephrine?

____________Serious Head Injuries
____________Chicken Pox
____________Dislocations
____________Hospitalization
____________Menstrual Cycle
____________Mononucleosis
____________Operations
____________Orthopedic Problems
____________Seizure Disorder
____________Serious Injuries
____________Skin Conditions
____________Speech Concerns
____________Other

Details: ____
____
____

Medications: Is your child currently taking medications? _______________
Name of medication(s) ____
Reason medication(s) is being taken____

Has anyone in your family died of Heart Disease or Sudden Death before the age of 50? ____________________

Does your child have any emotional problems that we should be aware of? _____________
Please explain: ____

May your child have a physical at school? ☐ Yes ☐ No

If your child has had a physical exam in the last 12 months, please fax a copy to your child's school building Nurse. (See fax numbers below)

Parent/Guardian Name Print: ______________________________**Signature:** ________________________ **Date:** _____________

Relationship to student: ☐ **Mother** ☐ **Father** ☐ **other:** __________________

Morrisonville Elementary
Brenda Martin 565-5923
Fax 565-5972

Saranac Elementary
Emily Brown 565-5844
Fax 565-5890

Saranac Middle School
Sarah Sorensen 565-5650
Fax 565-5706

Saranac High School
Beth Besaw 565-5806
Fax 565-5809