Gervais School District #1

HEALTH QUESTIONAIRE

STUDENT'S FIRST NAME ↓	STUDENTS'LAST NAME ↓
STUDENT'S DATE OF BIRTH:	**GENDER: ☐FEMALE ☐MALE**
GRADE:	
PARENT / GUARDIAN ↓	**HOME PHONE:**
	CELL PHONE:

******IF NO HEALTH ISSUES TO REPORT STOP HERE, SIGN AND DATE BELOW ******

PARENT / GUARDIAN'S EVALUATION OF STUDENTS HEALTH
(Mark appropriate areas and offer explanation when necessary)

ALLERGIES TO? (please list allergen(s) below)	Describe reaction the student experiences when he/she comes in contact with allergen.	Is the reaction life threatening?	**ASTHMA?** (please list things that trigger asthma)	**OTHER HEALTH CONCERNS** (list all pertinent health concerns) *please list any diet restrictions/requests that is **not** related to allergies under **Other** at the bottom of this column*
Animals? List animal (s)		Yes / No	**Animals?** List animal(s)	**Neurological:** including any vision issues, headaches, seizure, TBI…
Food? List food (s)		Yes / No	**Exercise or other physical activities**	**Endocrine:** Diabetes, thyroid, hormone imbalance…
Insects? List insect (s)		Yes / No	**Weather changes** (humidity, extreme cold or heat)	**Mental Health:** ADHD, ADD, depression, anxiety…
Medication? List medication (s)		Yes / No	**Upper respiratory infections or other common colds**	**Gastrointestinal:** Swallowing, encopresis, GERD…
Environmental? (List allergens, i.e. fragrances, pollen latex…)		Yes / No	**Environmental?** (List allergens, I.e. fragrances, pollen latex…)	**Urinary system:** Incontinence, kidney issues, frequent UTI…
Other (please list specifics)		Yes/ No	**Other** (please list specifics)	**Other:** (i.e. oral, musculoskeletal, nutritional)

Medications:
Does the student have medications to be given during school hours? **☐Yes ☐No**
*****_There will be some forms to be completed by parent/guardian for medications to be kept on campus._

For any health conditions listed above, please complete and sign the ***Authorization to Use and/or Disclose Educational and Protected Health Information form*** **on the back of this questionnaire**.

Parent / Guardian Signature **Date**

*****Please contact the Gervais School District nurse if you have any questions or concerns **503-792-3803 ext. 5076**

AUTHORIZATION TO USE AND/OR DISCLOSE EDUCATIONAL AND PROTECTED HEALTH INFORMATION

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.

_____ _____
Student/Child's Name Date of Birth

_____ **Gervais School District 290 First St. Gervais OR 97026**
Other Names Used by Student/Child School or Program Name

Name and address of health care provider/doctor authorized to:
☐Send/disclose protected health information
☐Receive/use educational information

_____
_____

Name and address of school/EI/ECSE program authorized to:
☐Send/disclose educational information
☐Receive/use protected health information

_____
_____

2. I understand that this information will be used for the following purposes (check all that apply):

☐Determining eligibility for Special Education, EI/ECSE, or other services	☐Developing an appropriate Individualized Education Program or Individualized Family Service Plan
☐Determining student/child's current levels of performance	☐Other (specify): Address health issues at school
☐Developing an individualized health plan	

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

☐Physician's Eligibility Statement	☐Educational Information	☐Psychological Evaluations
☐Health Assessment Statement	☐IFSP/IEP document	☐Social work reports
☐History and physical exam	☐Clinic records	☐Other: Health information that could impact student at school
☐Entire medical record	☐Communicable disease(s)	
☐Prenatal information	☐Progress notes	_____

4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, and discharge plan.

_____ Drug/alcohol diagnosis, treatment or referral information requested: _____
_____ HIV/AIDS related records requested: _____
_____ Mental health related information requested: _____
_____ Genetic testing information requested: _____

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.
b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524)
c. I may revoke this authorization at any time by notifying _____ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.
d. Federal policy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

_____
Signature of Parent/Legal Guardian/Student/Child **Date** **Relationship**

This authorization expires ____/_____/_____ (**month/day/year**) (**not to exceed one year from date of signature above**)