GERVAIS SCHOOL DISTRICT #1
HEALTH QUESTIONAIRE FOR SCHOOL NURSE

Student name:	School:
Date of Birth (mm/dd/yyyy):	Grade:
Gender: ☐ Female ☐ Male ☐ Non-Binary (X)	
Parent/Guardian name:	
Home phone:	Cell phone:

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

Does your child have any known allergies? ☐ Yes ☐ No Is the reaction life threatening? ☐ Yes ☐ No
List allergen(s) and reaction(s) _____

Does your child have a food allergy? ☐ Yes ☐ No Is the reaction life threatening? ☐ Yes ☐ No
List food allergies: _____

Does your child have Asthma? ☐ Yes ☐ No Is your child on medication for Asthma? ☐ Yes ☐ No
List medication: _____
List triggers: _____

Does your child have seizures? ☐ Yes ☐ No Does your child take medications for seizures? ☐ Yes ☐ No
List medication(s): _____

Does your child have a mental health condition? ☐ Yes ☐ No Does your take medications for this? ☐ Yes ☐ No
List condition(s) and medication(s): _____

Does your child have Diabetes? ☐ Yes ☐ No Is your child on medication(s) to manage Diabetes? ☐ Yes ☐ No
If yes, list medications: _____

Has your child had any hospitalization, surgeries, accidents or serious illnesses within the past year or anytime? ☐ Yes ☐ No
If yes, please elaborate _____

Is there any chronic condition or illness that I should be aware of that may limit your child's activities? ☐ Yes ☐ No
If yes, please elaborate _____

Does your child have any other medical or health problems to be aware of? ☐ Yes ☐ No
(i.e. Diet restrictions, Neurological, Gastrointestinal, Urinary, and/or any others)
If yes, please specify _____

MEDICATIONS: Does the student have medications to be given during school hours? ☐ Yes ☐ No

Any medication(s) that must be administered during school hours requires written permission from a physician as well as written permission from a parent/guardian. The medication must be brought to school (by an adult) in the original container appropriately labeled by the pharmacy or physician. **Please list medications:** _____

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** (mm/dd/yyyy)

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 Name Date of Birth (mm/dd/yyyy)

_____ **Gervais School District 290 First St. Gervais OR 97026**
Other Names Used by Student 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
☐ Determining student/child's current levels of performance
☐ Developing an individualized health plan
☐ Developing an appropriate Individualized Education Program or Individualized Family Service Plan
☐ Other (specify): Address health issues at school

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 **Date** (mm/dd/yyyy) **Relationship**

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