School Based Health Center (SBHC)
Permission and Medical History Form

Student's Name: _____ Date of Birth: _____

1) Is the student under the care of any medical specialist? ☐ Yes ☐ No

2) Has student seen a dentist within the last year? ☐ Yes ☐ No

3) Has student seen same dentist for more than one year? ☐ Yes ☐ No

1) Is the student currently taking any medications? ☐ Yes ☐ No

If YES, please list below including dosages and how often. (Include asthma inhalers and EpiPens) _____

_____

5) Do you have allergies? (food, medication, bees, etc.) ☐ Yes ☐ No

If YES, please specify: _____

Medical History: *Please check all boxes that apply and explain on the lines below:

- ☐ Hospitalization or Surgery
- ☐ Seasonal / Environmental Allergies
- ☐ Broken bones, Dislocations
- ☐ Muscle or Joint Injuries
- ☐ Neck or Back Injuries
- ☐ Heart Defects / Murmurs
- ☐ High Blood Pressure / Cholesterol
- ☐ Chest Pain during or after exercise
- ☐ Fainting or Blacking-Out
- ☐ Running / Exercise Problems
- ☐ Asthma / Breathing Issues
- ☐ Blood Disorders /Anemia / Sickle Cell
- ☐ Vision Problems (Contacts / Glasses)
- ☐ "Mono"
- ☐ TB or Positive Skin Test
- ☐ Skin Problems (Eczema, Psoriasis)
- ☐ Dental Problems (Pain / Bleeding)
- ☐ Concussions
- ☐ History of Seizures
- ☐ Headaches / Migraines
- ☐ Diabetes/Thyroid/Endocrine
- ☐ Weight or Eating Issues
- ☐ Females: Menstrual problems
- ☐ Stomach Problems
- ☐ Hearing Problems
- ☐ Any other medical problems

_____

_____

Mental Health History: *Please check all boxes that apply and explain on the lines below:

- ☐ Mood Disorder / Depression
- ☐ Anxiety / Panic / OCD
- ☐ Anger / Other behavioral issues
- ☐ Academic Concerns
- ☐ Cutting / Self-harm
- ☐ Learning Disorder / ADD / ADHD / Autism Spectrum
- ☐ Loss / Divorce / Deportation of family members
- ☐ Substance use / Vaping
- ☐ Eating / Significant Weight Loss or Gain
- ☐ Other unlisted concerns

_____

_____

Family History: *Please check all boxes that apply and explain on the lines below:

- ☐ Family member with heart disease
- ☐ Family member with high cholesterol
- ☐ Family member with diabetes
- ☐ Family member with mental illness (i.e. depression)
- ☐ Family members with alcohol / drug problems
- ☐ Family medical problems not addressed above

6) Has any sudden family member died of heart problems or sudden death before age 50? ☐ Yes ☐ No

Please specify which family member (Maternal / Paternal): _____

_____

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

I give permission to the CIFC Health School Based Health Centers and Newtown Middle School to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment, and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing.

I received the HIPPA Notice of Privacy Practices Notice ☐ Yes ☐ No

Date: _____ Signature : _____ Relationship to student: _____