Submitting the Health Services Student Emergency Information/Health History Form

The information does not automatically save to this form. Once you have completed the form, please save a copy of the form to your computer using your child's name in the title of the file. Please email the completed Health Services Student Emergency Information/Health History form to the nurse at the campus your student will be attending for the 2020-2021 school year (see below for email addresses).

If your student has received any immunizations during the past year, please email a copy of the updated shot record to the nurse as well.

The completed Health Services Student Emergency Information/Health History form and shot records, if needed, should be submitted to the following email address for your campus:

ELEMENTARY CAMPUSES:

Cibolo Valley Elementary -------------------------------- **drusso@scuc.txed.net**
Green Valley Elementary --------------------------------- **solsen@scuc.txed.net**
Paschal Elementary -------------------------------------- **efurlong@scuc.txed.net**
Rose Garden Elementary -------------------------------- **snodine@scuc.txed.net**
Schertz Elementary -------------------------------------- **wayers@scuc.txed.net**
Sippel Elementary --------------------------------------- **hndavis@scuc.txed.net**
Watts Elementary -- **jlaw@scuc.txed.net**
Wiederstein Elementary ----------------------------- **mcherrera@scuc.txed.net**

INTERMEDIATE CAMPUSES:

Jordan Intermediate ------------------------------------ **mshaffer@scuc.txed.net**
Schlather Intermediate ---------------------------------- **vmoreno@scuc.txed.net**
Wilder Intermediate ------------------------------------- **ksullivan@scuc.txed.net**

JUNIOR HIGH CAMPUSES:

Corbett Junior High ------------------------------------ **abroome@scuc.txed.net**
Dobie Junior High --------------------------------------- **mmudge@scuc.txed.net**

HIGH SCHOOL CAMPUSES:

Allison L Steele Enhanced Learning Center ------------- **dthein@scuc.txed.net**
Byron P Steele High School High School ------------- **lblevins@scuc.txed.net**
Samuel Clemens High School -------------------------- **twatson@scuc.txed.net**

SCUC Independent School District - Health Services Student Emergency Information/Health History **N1**

Student's Name: Last	**First**	**M.I.**	**Student ID#**
Grade	☐Male ☐Female	Birthdate	

Home Address – Street, City, Zip	Home Phone Number

Parent/Guardian Name	Email Address	Cell Number	Work Number
Parent/Guardian Name	Email Address	Cell Number	Work Number

Please list Persons who will assume temporary care of AND / OR pick up your child if you cannot be reached:

Name	Cell Number	Work Number	Relationship to Student
Name	Cell Number	Work Number	Relationship to Student

In an effort to provide safe, informed care for your child at school, each year the SCUCISD Health Services Department requires the following information to complete your child's enrollment. Medical Information you provide about your child is a confidential education record. SCUCISD keeps all medical information about your child confidential as required by the Family Educational Rights and Privacy Act and other applicable laws. However, health information about your child will be communicated to SCUCISD school personnel who require the information to better serve your child.

Health History: Check all health conditions that apply

☐ **Student has a 504 PLAN for health related accommodations**

☐ **ADHD** ☐ **ADD** ☐ Medications taken at home ☐ Medications taken at school ***DOCTOR ORDER REQUIRED (See Nurse)***

☐ **ALLERGIES** ***(Specify & describe below):*** ☐ Drug ☐ Food ☐ Insect

☐ DRUG - Drug(s) & Reaction____

☐ STUDENT REQUIRES EPIPEN and / or BENADRYL AT SCHOOL ***DOCTOR ORDER REQUIRED (See Nurse)***

☐ FOOD - List Food(s) & Reaction____

FOOD ALLERGY ACTION PLAN FROM DOCTOR REQUIRED FOR SEVERE FOOD ALLERGIES (See Nurse)

☐ Insect – List Insect(s) & Reaction: ____

☐ **ASTHMA** ***ASTHMA ACTION PLAN FROM DOCTOR REQUIRED FOR INHALERS / NEBULIZERS TO BE GIVEN AT SCHOOL (See Nurse)***

☐ **DIABETES** ***(Specify):*** ☐ Type 1 ☐ Type 2

DIABETIC MANAGEMENT PLAN FROM DOCTOR REQUIRED FOR TYPE 1 DIABETES (See Nurse)

☐ **EMOTIONAL/PSYCHOLOGICAL DISORDER** Specify: ____

☐ **HEARING PROBLEMS :** ☐ Hearing Aid ☐ Cochlear Implant Other: _______________________________

☐ **HEART CONDITION** ☐ Heart Defect ☐ High Blood Pressure ☐ Other:_______________________

☐ **KIDNEY/URINARY PROBLEMS** Explain: ____

☐ **MEDICATION(S) TAKEN AT HOME/SCHOOL:** ____

****** ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A WRITTEN ORDER FROM YOUR CHILD'S DOCTOR EVERY SCHOOL YEAR (See Nurse)******

☐ **MIGRAINES/HEADACHES** Explain: ____

☐ **SEIZURE DISORDER** ***SEIZURE ACTION PLAN FROM DOCTOR REQUIRED (See Nurse)***

Date of last seizure________________ Type of seizures_______________________________

☐ **STOMACH / INTESTINAL PROBLEMS** Explain: ____

☐ **VISION PROBLEMS:** ☐ Wears glasses ☐ Contact Lenses ☐ Other: _______________________

☐ **SPECIAL PROCEDURE(S) AT SCHOOL** ***DOCTOR ORDER REQUIRED (See Nurse)***: _______________________

☐ **OTHER HEALTH CONCERNS:** ____

☐ ***MY CHILD HAS NO HEALTH CONDITIONS AND WILL NOT REQUIRE MEDICATION / SPECIAL PROCEDURES AT SCHOOL***

I, the undersigned, do hereby authorize officials of Schertz-Cibolo-Universal City Independent School District to contact directly the persons named on this form in case of emergency for said child. In the event parents or other persons named on this form cannot be contacted, school officials are hereby authorized to take whatever actions are deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Date: ______________________________ Signature of Parent/Guardian: ______________________________ *

*** Due to COVID-19, digital signatures are temporarily being accepted. Once normal operations resume, the campus may request your actual signature on all documents.**