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	<u>solsen@scuc.txed.net</u>
Paschal Elementary	<u>efurlong@scuc.txed.net</u>
Rose Garden Elementary	<u>snodine@scuc.txed.net</u>
Schertz Elementary	<u>wayers@scuc.txed.net</u>
Sippel Elementary	<u>hndavis@scuc.txed.net</u>
Watts Elementary	j <u>law@scuc.txed.net</u>
Wiederstein Elementary	mcherrera@scuc.txed.net

INTERMEDIATE CAMPUSES:

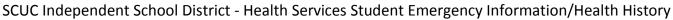
Jordan Intermediate	mshaffer@scuc.txed.net
Schlather Intermediate	vmoreno@scuc.txed.net
Wilder Intermediate	ksullivan@scuc.txed.net

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



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Student's N	Name: Last	lame: Last First			M.I.	M.I. Student ID#			
Grade	□Male □F	emale	Birthdate						
Home Address – Street, City, Zip Home Phone Number					umber				
Parent/Guardian Name En			Email Ad	ldress	Cell Number	r		Work Number	
Parent/Guar	Parent/Guardian Name E			Email Address		Cell Number	Cell Number		Work Number
Please list	Persons who	o will as	sume temp	orary ca	re of <u>AND / OR</u> pick up	your child	if you car	nnot be	reached:
Name				Cell N	Cell Number V		Work Number		Relationship to Student
Name				Cell N	lumber	Work Num	ber		Relationship to Student
information all medical in	to complete you nformation abou	ur child's e ut your chi	enrollment. M ild confidentia	edical Inf I as requi	hool, each year the SCUCISD Formation you provide about yeld by the Family Educational SCUCISD school personnel wh	our child is a c Rights and Pr	confidentia ivacy Act ar	l education	on record. SCUCISD keeps applicable laws. However,
Health	History:	Checl	k all hea	Ith co	onditions that ap	ply			
□ Studen	t has a 504	PLAN fo	or health re	elated	accommodations				
□ ADHD 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 - 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: □ Cothlear Implant Other: □ HEART CONDITION □ Heart Defect □ High Blood Pressure □ Other: □ MEDICATION(S) TAKEN AT HOME/SCHOOL: □ MEDICATIONS GIVEN AT SCHOOL REQUIRE A WRITTEN ORDER FROM YOUR CHILD'S DOCTOR EVERY SCHOOL YEAR (See Nurse)*** □ MIGRAINES/HEADACHES Explain: □ MIGRAINES/HEADACHES Explain:									
					M DOCTOR REQUIRED (Se	•			
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:		ate: 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.