Dr. Titus Hines
Superintendent

Southeast Mississippi Rural Health Initiative, Inc. (SeMRHI)

Perry County School District

105 South Main Street
New Augusta, MS 39462
601-964-3211

STUDENT HEALTH HISTORY

Dear Parent/Guardian:

Please complete this health history and return it to the teacher or principal.
We would like your child to gain the most from his/her school experience. In order for us to assist your child in accomplishing this, it is necessary for us to have a complete understanding of the factors affecting his/her development.

Student Name________________________School____________________Grade ________
Last First Middle

Social Security # ______-_______-_______ Date of Birth:_______/______/_______ Sex: ❐Male ❐ Female

Address ____
Number and street and/or P. O. Box City, State, Zip

Phone: Home ________________________ Work __________________________ Cell ___________________________

Email address: ____

Student Ethnicity: Are you Hispanic or Latino Descent? ❐ Yes ❐ No

Student Race: ❐ American Indian/Alaska Native ❐ Asian ❐ Black/African American
❐ Native Hawaiian ❐ White/Caucasian ❐ Other Pacific Islander
❐More than one race ❐ Unreported/Refused to report

Student Language: ❐ English ❐ Spanish ❐ Vietnamese ❐ French ❐ Creole ❐ Arabic ❐ Other

Parent (s)/Guardian (s):______________________________________ DOB_____/_____/_______
Mother's Maiden Name: _____________________________________

How many people live in your household?_____ ❐ Refuse to report
What is your annual household income? ☐$5,000 or less ☐ $5,001 - $10,000 ☐ $10,001 - $15,000
☐ $15,001 - $25,000 ☐$25,001 - $50,000 ☐$50,001 - $ 75,000 ☐ $75,001 - $100,000 ☐over $100,000

1. When did your child last have a physical examination?_______/________/________
   Name of Physician or Clinic: ____

2. **Childs Health History:** (check where appropriate)

❐ Asthma ❐ Anemia ❐ Injury
❐ Diabetes ❐ Seizures/Convulsions ❐ Heart Problems
❐ Vision Problems ❐ Frequent Ear Infections ❐ Hearing
❐ Sickle Cell Anemia ❐ Frequent Headaches ❐ ADHD
❐ Skin Problems ❐ Stomach Problems ❐ Problems Sleeping
❐ Frequent Colds/bad enough to miss school

Allergies to (please list): ❐ Drugs___________________❐ Food____________________❐ Insects _________________

Other Health Problems: ____
Explain: ____

Does your child take medication: ❐Yes ❐No If Yes, list name of Medication(s) ______________________________

____

Has child been hospitalized for any reason since birth? ❐Yes ❐ No If yes, explain:___________________________

____

Is there anything more about this child's health that you think is important for us to know?
Explain: ____

3. **Family History:** (Check and indicate relationship to child)

❒ Diabetes ___________________	❒ Cancer ______________	❒ High Blood Pressure _______________
❒ Birth Defect ________________	❒ Anemia ______________	❒ Epilepsy _________________________
❒ Sickle Cell Anemia __________	❒ Heart Disease _________	❒Learning Problems _________________
❒ Mentally Disabled____________	❒ ADHD _______________	❒ Other ___________ ______________

4. Who should we contact in case of an emergency? (list 3 different people and telephone numbers)

Name	Relation to Child	Phone Number
___________________________	____________________________	_________________________
___________________________	____________________________	_________________________
___________________________	____________________________	_________________________

Required Insurance Information:

<u>The above-named student has the following HEALTH care insurance coverage:</u>

1. Medicaid/CHIP#: ________________________
2. Health Insurance:________________________Insurance Address: _______________________________________
3. Insurance holder (Subscriber)____________________________SS#:____-_____-_______DOB:____/____/______

   Insurance ID#____________________________Group #: __________________________
4. Please check here if you do not have any **HEALTH** insurance that covers the student __________

Dental: Would you like for your child to receive dental services? ❒ Yes ❒ No

<u>If yes, the above-named student has the following DENTAL insurance coverage:</u>

1. Dental Insurance:________________________Insurance Address:_____________________________________

   Insurance holder (Subscriber)____________________________SS#_____-_____-______DOB:_____/____/______

   Insurance ID#_________________Group #:________________Employer name: __________________________
2. Please check here if you do not have any **DENTAL** insurance that covers the student __________

I understand that my consent is required by Southeast Mississippi Rural Health Initiative, Inc., d/b/a Perry County School District, before my child can receive services. I hereby provide consent for the above-named student to receive health care services in the area of vision, hearing, scoliosis, behavior/mental health and general health at no cost to the parents of the Perry County School District. I authorize the designated health and dental care professionals to provide necessary and/or advisable assessment for the above-named student. Any third-party coverage will be billed for payment. Igive permission for necessary medical and dental test and treatments. I further release and hold harmless the Perry County School District and do give, grant, and release from any liability, costs, or loss which my child or I may sustain or incur now, or at any time in the future or as a direct or indirect result of any treatment, consultation or other action or inaction by the Perry County School District.

By completing the student health history form, **<u>I acknowledge that my child will receive the above services from Southeast Mississippi Rural Health Initiative, Inc. d/b/a Perry County School District until they graduate, withdraw from school, or transfer to another school district</u>.** At any time, I can opt-out of the program by contacting Southeast Mississippi Rural Health Initiative, Inc. at 601-545-8700.

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Parents/Guardian Signature Date