Grade Level _____
2025-2026 School Year

Black Hawk School District
Health Form

Complete this form every year for each student. This ensures we have current information on file if we need to reach someone in an emergency and provide the appropriate medical care.

_____

Last Name First MI Age

_____

Home Address Home Phone

Legal Guardian(s) if applicable_____

_____

Father Place of Work Work/Cell Phone Occupation

_____

Mother Place of Work Work/Cell Phone Occupation

Others at home: Sisters _____ **Brothers** _____

Step-Siblings_____

_____

If not living with both parents/guardians, what is the custody arrangement?

_____

_____

_____

_____

Emergency Care Plan

Primary Physician _____ **Clinic Affiliation** _____

Phone Number _____ **Last Visit** _____

-OVER-

This section should be completed ACCURATELY. In past, we have had incomplete information and if medical emergency arises, we need to be able to provide competent care to your child.

Medical Condition/Frequent Illness/
Special Healthcare Needs **Emergency Care** **Medications**

_____

_____

_____

_____

_____

_____

_____

Dentist _____ **Last Visit** _____

Phone Number _____

Last Eye Exam _____ **Glasses or Contacts?** _____

Preferred Hospital (in case of emergency) _____

PLEASE list <u>ALL MEDICATION</u> allergies and the reaction.

_____

_____

_____

PLEASE list <u>ALL FOOD ALLERGIES</u> and the reaction. If student requires an accommodation (special milk for lactose intolerance) a note from the physician will be required.

_____

_____

_____

Is the student Fully Immunized _____
Partially Immunized _____

*****Please see attached required immunizations for the State of Wisconsin*****

Parent/Guardian Signature _____ **Date** _____

Printed Parent/Guardian Name _____

Black Hawk School District

CONSENT for Over-the-Counter (OTC)/Non-Prescription Medication Administration Authorization

Please complete *both* sections

STUDENT NAME: _____ BIRTHDATE: _____

GRADE: _____

*This form will need to be completed **annually**. It will be kept on file in the school health office. If there is not a form signed, a phone call to a parent/guardian on one occasion will be made. The form will then be sent home to be signed and returned. Acetaminophen, Ibuprofen, Benadryl, and Tums will be available. If you prefer, you may send a *separate original* labeled bottle for your child.

FOR COMPLETION BY PARENT/GUARDIAN

Please initial each medication you give permission for administration at school. Circle the preferred form of medication.

_____ **Ibuprofen (Advil)** (for pain, fever) Liquid Chewables Tablets

_____ **Acetaminophen (Tylenol)** (for pain, fever) Liquid Chewables Tablets

_____ **Benadryl** (for allergic reaction, itching) Liquid Tablets

_____ **Tums (Regular Strength)**

___ I give permission for the above medication(s) to be given as directed

Qualified persons trained in medication administration have my permission to administer the above medications as directed on the label.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Home Phone: _____ Work Phone: _____

Date	Time	Medication	Dosage	Reason	Staff Initials

FERPA/HIPPA CONSENT (optional)

Must Sign the BACK SIDE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____

Date of Birth: _____

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____
(2) _____

To provide health information from the above-named child's medical record to and from:

Black Hawk School District

202 East Center Street

South Wayne, WI 53587

School District Official to

Which Disclosure is Made

Sara A Kaster APNP, RN, FNP-BC

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: __ All minimum necessary health information; or

__ Disease-specific information as described: _____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtain another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____

Parent/Guardian Printed Name

_____

Parent/Guardian Signature Date