

## 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

**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**

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**Dentist** \_\_\_\_\_ **Last Visit** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Last Eye Exam** \_\_\_\_\_ **Glasses or Contacts?** \_\_\_\_\_

**Preferred Hospital (in case of emergency)** \_\_\_\_\_

**PLEASE list ALL MEDICATION allergies and the reaction.**

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

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**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: \_\_\_\_\_

[illegible]

## 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:**

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Parent/Guardian Printed Name

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Parent/Guardian Signature

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Date