Greeley County Health Greeley Department
County School Nurse

P.O. Box 537—510 W Lawrence
Tribune, KS 67879
(620)376-4200

Privacy Statement

I certify that all information below is correct to the best of my knowledge. I understand that I will be responsible for services in which KanCare and/or my private insurance does not cover. I authorize release of immunization record for the student listed below to any licensed physician, primary care provider, hospital, local health department, educational institution, or regulated child/adult care facility. I understand that any other health information for the client listed above will not be released without the written authorization from the student's responsible party. I authorize the release of any medical or other information necessary to process claims for billing purposes. I acknowledge that I have received or been offered a copy of the Agency's **Notice of Privacy Practices** with the effective date of August 1, 2017.

Statement of Consent

In order to better serve the health needs of my child, I hereby give my permission for the transfer of health information to school and other appropriate health professionals, including the Kansas Immunization Registry and DAISEY programs. I authorize school personnel to obtain emergency medical care for my student in the event I cannot be reached. If transportation by ambulance is required, this may be obtained. I also give permission for health screenings to be completed, including, but not limited to: height/weight, hearing, vision, dental, illness, and injury. In addition, all the information provided below is accurate to the best of my knowledge.

Parent/Guardian Signature_____ Date _____

Puberty Education (4th & 5th Grades) / Sex Education (6th – 12th Grades) Parent Initials: _____
(Choose and circle one) I **DO** / **DO NOT** want my child to participate in his/her grade's puberty/sex education.

Child's Name: Age: Grade:

Date of Birth: Sex: Student's Cell #:

Physical/Home Address: P.O. Box/ Mailing Address: **OR** Same as physical address

Mother's/Guardian's Name: Cell Phone: Home Phone: Work Phone:
Date of Birth:

Father's/Guardian's Name: Cell Phone: Home Phone: Work Phone:
Date of Birth:

Student lives with:
☐ Both Parents
☐ Mother / Stepmother
☐ Father / Stepfather
☐ Grandparent(s)
☐ Legal Guardian(s)
☐ Other_____

Language spoken at home:
☐English ☐Spanish

Number of people in household: _____

Who should be contacted 1st, 2nd,3rd?
_____
_____
_____

In case of emergency and parent or guardian can not be reached, contact:

1. Name: Day Phone: Cell:
2. Name: Day Phone: Cell:

Is student covered by UnitedHealthcare, Sunflower or Aetna? ☐Yes (if yes, circle one) ☐No
Identification number _____

Office Use only: KanCare application given ☐ Yes ☐ No

Is student covered by private insurance? ☐Yes ☐No
Insurance Company_____ **Identification number** _____

PLEASE COMPLETE BOTH SIDES OF FORM!!!

HEALTH CONDITIONS: (Mark those that apply.)

☐ ADHD
☐ Anaphylactic Reactions
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Broken Bones
☐ Concussion/Head injury
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections (chronic/numerous)
☐ Frequent Headaches
☐ Other Conditions
☐ Frequent Stomachaches
☐ Frequent Throat Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Heart or Blood Conditions
☐ Headaches/migraines
☐ Hearing problem/condition
☐ High Blood Pressure
☐ Kidney Disease
☐ Learning Difficulties
☐ Menstrual Cramps
☐ **NONE**
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Seizure/Convulsions/Epilepsy
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition
☐ Vision problem/condition

Please explain any answers that you checked above. Indicate any information useful to the nurse/teacher in relation to any of these health conditions: _____

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:			**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

ALLERGIES: ☐ **No Allergies**

☐ **Food** ☐ **Medicine** ☐ **Insects** ☐ **Environmental** ☐ **Other**

☐**Mild** ☐**Moderate** ☐**Life-threatening** ☐**EpiPen prescribed**

Describe what causes allergies and the symptoms exhibited:

_____

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐glasses ☐contacts ☐hearing aid(s) ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer ☐special diet
PLANS	**YES**	**NO**	
During school	☐	☐	☐IEP ☐IHP ☐Emergency Action Plan ☐504 Plan

Physician: _____ Dentist: _____ Specialist(s): _____

Please list the dates of your child's most recent exams (that were done someplace other than school):

Dental:_____ (Month/Year) Vision:_____ (Month/Year) Hearing:_____ (Month/Year)

If child did not attend Greeley County Schools prior to this year:

School last attended:_____ City:_____ State:_____