

**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 June 1, 2010.

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:** _____
Date of Birth: _____ **Home Phone:** _____
Work Phone: _____

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

Student lives with: _____ **Language spoken at home:** _____ **Who should be contacted 1st, 2nd, 3rd?** _____
 Both Parents English Spanish _____
 Mother / Stepmother _____
 Father / Stepfather **Number of people in household:** _____
 Grandparent(s) _____
 Legal Guardian(s) _____
 Other _____

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, SunflowerState or Amerigroup? Yes (if yes, circle one) No
Identification number _____

Is student covered by private insurance? Yes No **Office Use only: KanCare application given** Yes No
Identification number _____ **Insurance Company** _____

PLEASE COMPLETE BOTH SIDES OF FORM!!!

