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

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:

Physical/Home Address:

Same as

Mailing Address:

OR physical address Cell Phone: Mother's/Guardian's Name: Home Phone: Work Phone: Date of Birth: Cell Phone: Father's/Guardian's Name: Date of Birth: Home Phone: Work Phone: Student lives with: Language spoken at home: Who should be contacted 1st, 2nd, 3rd? □English □Spanish ☐ Both Parents ☐ Mother / Stepmother ☐ Father / Stepfather Number of people in household: \square Grandparent(s) ☐ Legal Guardian(s) □ Other In case of emergency and parent or guardian can not be reached, contact: 1. Name: Day Phone: Cell:

Is student covered by UnitedHealthcare, SunflowerState or Amerigroup?

Tyes (if yes, circle one)

Day Phone: Cell:

Office Use only: KanCare application given ☐ Yes ☐ No Insurance Company_____

PLEASE COMPLETE BOTH SIDES OF FORM!!!

Is student covered by private insurance? □Yes □No

Identification number

Identification number _____

HEALTH CONDITIONS: (N	Aark tho	ose 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] Frequer] GI Cond] Heart of] Headacl] Hearing] High Blo] Kidney I] Learnin	ent Stomachaches ent Throat Infections ditions (ulcer, reflux, IBS) or Blood Conditions ches/migraines og problem/condition lood Pressure or Disease ong Difficulties rual Cramps			☐ 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 relation to any of these health c	-		bove.	Indica	ate any	y information useful to the nurse/teacher in
Has your child ever:				YES	NO	If Yes, please explain and include date:
Been hospitalized	•					
Had an operation	·					
Had an injury requiring an Emer	gency R	oom visi	it			
Missed 5 days of school in a rov						
Worn dental bridge, braces or n			, ,			
Have any family members unde			ver:			If Yes, please specify:
Had a heart attack						
Had other serious health proble	ems					
Describe what causes allergies						
CURRENT MEDICATIONS	YES	NO	Plea	se list	name	e, dose, time(s)
Given at school						
Taken at home						
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply			
			□glasses □contacts □hearing aid(s) □wheelchair			
During or outside of school	Ш		Dother:			
TREATMENTS	YES	NO				
During or outside of school			□ insulin/blood glucose monitoring □ inhaler/nebulizer □ special diet			
PLANS	YES	NO				
During school				P DII	HP \square	Emergency Action Plan □504 Plan
Physician: Please list the dates of your child Dental:	ld's mo		t exan	ns (tha	t were	Specialist(s): e done someplace other than school): Hearing:
Month/Year	V	151011				
				Month/Y	ear	Month/Year
If child did not attend Greeley C School last attended:	County	Schools	s prior	to this	year:	