Community
Health Network

STUDENT'S NAME _____ **DOB** _____
SCHOOL _____ **GRADE** _____ **TEACHER** _____

Dear Parents,

It is important for the school to be aware of any special health concerns your child may have that affect him/her while during the school day. Health needs often change, so information should be updated each year. Please complete and return this form to school.

_____ My student has no health problems or limitations that will affect him/her at school.
_____ My student has the following medically-diagnosed health concerns that may affect him or her during the school day. (Please check box/boxes and EXPLAIN below):

_____Asthma
_____Allergies (life-threatening)**
  _____Bees/Insects
  _____Foods
  _____Latex
_____Bone/Joint Problems
_____Cancer
_____Diabetes
_____Hearing or Vision Deficits (not glasses)
_____Heart Condition
_____High Blood Pressure
_____Kidney Problems
_____Seizures or Epilepsy
_____Other (Explain Below)

PLEASE LIST ANY ALLERGIES TO FOOD OR MEDICINE, OR EXPLAIN ABOVE:

_____

_____

_____

****IF the student is new to OR re-enrolling in _____school and has a serious health condition or life-threatening food allergy requiring epinephrine, please know that doctors' orders are necessary for diagnosing and altering a USDA school meal. Please have your child's doctor-signed action plan and appropriate medications to the school nurse as soon as possible.**

*Health information is confidential. The school nurse cannot share this information with the faculty/staff at your child's school without signed parent permission. If it is medically necessary for the above medical information to be shared with the staff please sign below and contact the Community school nurse at your child's school.

_____ _____
Date Parent/Guardian Signature and Telephone Number

Community Health Network

Request to Administer Medication to
STUDENT DURING THE SCHOOL DAY
2019-2020

If it becomes necessary for a student to take medication or receive treatment during the school day, the parent or guardian must complete this request form and file it in the school nurse's office. If the medication or treatment is physician-prescribed, the parent or guardian must submit a written prescription from the child's physician or the current pharmacy label with the request. A physician's order is also necessary for prescription samples that may have been released to student, or for any over-the-counter medication that is not recommended for children under age twelve.

All other over-the-counter medication must be in the original container labeled with the student's name and date of birth. Label instructions will be followed for all over-the-counter medicine unless otherwise prescribed by a physician.

This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

Parent's or Guardian's Authorization

I request that the medication described below be administered to my child/ward at the times specified during the school day. I will give the nurse the medication in its original container or current prescription bottle.

I understand that a parent or guardian will transport all medication to and from school for grades K-8. Medications must be picked up by the last day of school, or medications will be discarded.

☐ I give my permission for my child in grades 9-12 to bring home any unused medication.

I understand that a separate form must be completed for each medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school nurse clinic.

_____
Student's Name (Please Print)

Student's Date of Birth: _____/_____/_____
Month Day Year

_____
Name of Medication

Prescribed_____ Over-the-Counter_____

_____
Days Medication to be given

Times(s) to administer: _____a.m. _____p.m.

_____
Amount of Medication to be given

Lot # or Rx #_____

_____
Purpose of Medication

Refrigeration Required? Yes_____ No _____

_____
Signature of Parent or Guardian

_____
Date

_____
Printed Name

_____/_____/_____
Phone: Home / Cell / Work

Community Health Network

Consent/HIPAA Authorization
School Nurse
Health Clinic Services

School: _____ **Grade** _____ **Effective July 1, 2019 – June 30, 2020**

I give permission for _____
Please print students: Last Name, First Name Middle Initial Date of Birth

To receive health services from the school nurse health clinic (Clinic) at my child's school. I understand that Clinic personnel cannot take care of all the health needs my child may have. However, if my child is not already under the regular care of a doctor or clinic, I will work with the Clinic to choose one.

I. I give consent for my child to receive Clinic services: I have read the information about the Clinic and understand what services the Clinic may provide, which include, but are not limited to: first aid/emergency care, referrals to health providers in the community, nutrition services, health education, health screenings and immunization information. It will be my responsibility to notify the Clinic staff about changes in guardianship, the child's living or custody arrangements, and contact numbers.

Signature of Parent or Guardian (if student under age 18): _____ Date: _____
Signature of Student (if 18 or older or emancipated): _____ Date: _____

NURSING SERVICES WILL NOT BE PROVIDED WITHOUT CONSENT AS REQUIRED BY STATE LAW.

II. Information Privacy: We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your child's personal health information (PHI). You have the right to receive this notice prior to signing this consent. The current notice will be posted at your child's school, on Community's website, and copies are available upon request by asking the Clinic staff.

_____ **(Parent's Initials)** I acknowledge that I have access to a copy of the **Community Health Network NOTICE OF PRIVACY PRACTICES,** via Community's website. (Paper copies upon request.)

III. Release of Information: I hereby authorize the Clinic to disclose the PHI of student name listed above: The student's PHI that may be disclosed under this Authorization includes records and reports of medical services provided to the student at the Clinic, including but not limited to the evaluation, diagnosis and treatment of the student's injuries and illnesses. The PHI may be disclosed for clinic administration purposes, to the applicable school administration or staff to evaluate the student's eligibility to participate in school activities, or to resolve grievances. In addition, I give my consent to the school-based health clinic staff to look at my child's full school record, including attendance, in order to provide information that may assist the clinic staff in helping my child. I understand that the Clinic will not restrict services to the student based on my decision not to sign this Authorization, but that the student's participation in certain school sponsored activities may be conditioned on the signing of this Authorization.

Expiration of Authorization: As listed above. I understand that I may revoke this Authorization in writing at any time prior to its expiration date, except to the extent that action has been taken by the Clinic in reliance on this Authorization, by sending a written revocation to a member of the Clinic staff. I understand that the PHI released by the Clinic may be subject to re-disclosure by any recipient and no longer protected by federal or state privacy laws.

Signature: _____ **Date:** _____

Signature of Student (if 18 or older or legally emancipated): _____ **Date:** _____

Community Health Network

Indiana State Department of Health
Children & Hoosiers Immunization Registry Program
CHIRP

I,_____ , give [Name of School] , permission to release the following information concerning my child, _____ (Name of Child), to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

CHILD'S NAME, IMMUNIZATION DATA, SEX, ETHNICITY, PARENT'S NAMES, ADDRESS, AND PHONE

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Signature Date

_____
Printed Name of Parent or Guardian

_____ _____
Address Telephone Number

_____ _____
Child's Name Date of Birth

_____ _____
School Grade

Community Health Network

Request for Student to Possess and Self Administer Medication 2019-2020

A student may possess and self-administer medication for a chronic disease or medical condition ONLY if the parent or guardian annually files with the clinic this form signed by the parent or guardian and ***BY A PHYSICIAN***. This form will be valid for one school year only, and a new form filled out each school year.

Parent or Guardian Authorization

I am the Parent / Guardian (circle one) of the student identified below. I authorize _____school to permit this student to possess and self-administer the medication identified below on school property and during school time.

_____ _____
Student's Name (Please print) Name of medication

_____
Purpose of medication

Check one…**both still require a PHYSICIAN'S SIGNATURE** Prescribed?___Over the Counter?____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name Phone Number

Physician's Statement

I am a licensed physician. I provide medical services to _____
(name of student) and have prescribed _____*(name of medication)*
for this patient. I certify that the following statements are true and accurate:

A. An acute or chronic medical condition exists for which the above named medication is prescribed
B. The student named above has been given instructions as to how to self-administer the medication; and
C. The nature of the disease or medical condition requires emergency administration of the medication

_____ _____
Physician's Signature Date

_____ _____
Physician's Name Printed Phone Number

_____
Physician's Address

Student's Statement

I agree to use the above medication in accordance with school policies. I will not share this medication with any other students, I will keep it on my person at all times, and I will not use it for any other purpose than stated by my physician.

_____ _____
Student's name Date