A note from the School Nurse:

We are very excited that you have chosen to have your child be a part of the Black Hawk School District family! We strive to create a healthy learning environment for each and every student. To be successful, we ask that you take some time to complete the forms attached in this packet and return to the school prior to the start of the school year.

I have also enclosed the OPTIONAL consent form for the FREE dental clinic from Seal-A-Smile. They visit the school throughout the school and perform dental services. Flu shots and other vaccines will be offered at a later date through Lafayette County pending approval and availability of staff. The Lions Club will also be performing FREE vision screenings throughout the year. I will also be providing hearing screening for grades 4K through 2nd grade. Dates and times to be announced as they are scheduled.

Also included is a FERPA/HIPPA consent form. I ask that you fill this out completely in the event that I need to make contact with your child's doctor for any health reason that may impact their school life.

We also include an OTC Medication Authorization Form (Tylenol, Ibuprofen, Benadryl, etc) and a Prescription Medication Authorization Form that should be completed if you student needs to be administered ANY medication throughout the school day. This would include inhalers that middle and high school students are allowed to have in their possession.

You may contact me at any time for ANY health related questions or concerns. Please do not hesitate to reach out as we are partners in keeping your child healthy and having a successful school year!

Thank you for taking the time to complete these forms. WELCOME to you and your student!

Sincerely,

Sara A. Kaster MSN, APNP, FNP-BC
Black Hawk School Nurse
Office 608-439-5400 x111
Email: kassar@blackhawk.k12.wi.us

Checklist of Required Health Forms

______ Black Hawk School District Health Form

______ Kindergarten Physical Examination Form

______ Kindergarten Eye Health Examination Report

______ Student Immunization Record

The date (month, day, and year) of each immunization must be entered on the Student Immunization Record. Waivers are available for religious, health, and personal conviction reasons. You may view your child's immunization record from your computer on the Wisconsin Immunization Registry (WIR). The internet address is https://www.dhfswir.org/

______ Consent for Prescription Medications

______ Consent for OTC/Non-Prescription Medications

______ FERPA/HIPPA Consent (optional)

______ Seal-A-Smile (optional)

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:

____

Parent/Guardian Printed Name

____

Parent/Guardian Signature   Date

Grade Level ________
2023-2024 School Year

Black Hawk School District
Health Form

Complete this form each year for your 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

____
Home Address Phone

Legal Guardian(s) if applicable____

____
Father Place of Work Work Phone Occupation

____
Mother Place of Work Work Phone Occupation

Others at home: Sisters ________________________ **Brothers** __________________________

Step-Siblings____

____

Emergency Care Plan

Primary Physician _________________________________ **Last Visit** ____________________

Phone Number _____________________________

This section should be completed ACCURATELY. It is imperative this information is accurate and correct for the upcoming school year. In past, we have had incomplete information and if medical emergency arises, we need to be able to provide competent care.

Medical Condition__________**Emergency Care** __________________**Medications**__________

____

____

____

____

____

____

____

Dentist ____ **Last Visit** ____________________

Phone Number ___________________________

Last Eye Exam ___________________________ **Glasses or Contacts?** __________________

Preferred Hospital (in case of emergency) ____

If you child is ill and you cannot be reached at home or work, who can we call?

Name ___________________________________ **Phone** ______________________________

Relationship ______________________________

Name ___________________________________ **Phone** ______________________________

Relationship ______________________________

PLEASE list ALL MEDICATION allergies and the reaction.

____

____

____

PLEASE list ALL FOOD ALLERGIES and the reaction.

____

____

____

Does your family have adequate access/funds for food? ________________________________

If not, would you be interested in participating in the Warrior Backpack Program? ___________

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: ______________________________

Date	Time	Medication	Dosage	Reason	Staff Initials

Black Hawk School District

CONSENT for PRESCRIPTION MEDICAITON

Please complete *both* sections

STUDENT NAME: ________________________________ BIRTHDATE: __________

GRADE: ______________

*This form will need to be completed **annually** if your child receives daily medications at school.

FOR COMPLETION BY PHYSICIAN or HEALTH CARE PROVIDER

Medication **Dosage** **Frequency**

____

____

____

Side Effects: ____

PHYSICIAN/PROVIDER SIGNATURE: ______________________________ **DATE:** _________

Clinic Address: ____ Phone: _________________

FOR COMPLETION BY PARENT/GUARDIAN

___ I give permission for the above medication(s) to be given as directed and/or communicate with the provider(s) if necessary.

I authorize trained staff to administer this medication(s) at school and if the need arises the school nurse can communicate with the physician/health care provider as necessary regarding this medication. I authorize health personnel under HIPPA and FERPA to communicate health information on a need to know basis. This allows for conversation with administration per school nurse and as necessary with teaching and support staff.

PARENT/GUARDIAN SIGNATURE: _________________________________ **DATE:** ________

Home Phone: ___________________________ Work Phone: ______________________________

***Medication MUST be in the original prescription bottle.**
***The label must be current with student's name, medication, and date.**
***Dosage changes require <u>written notice with provider/health care provider and parent/guardian signature.</u>**