

SOUTHWEST HIGH SCHOOL
1685 Hollister Street. San Diego, CA 92154
(619) 628-3670
Fax: (619) 628-3770

Dear Parents and Students of Southwest High School:

Southwest High School has collaborated with San Ysidro Health (SYH) and Scripps Family Medicine Residency Program to make primary health care services available to students at the school-based health center. Our collaboration has maintained a school-based clinic at Southwest High School since 2007.

SYH offers students medical care as well as assistance for families to enroll in health coverage programs such as Medi-Cal, Healthy Families and other similar programs.

SYH and Scripps physicians are available at Southwest High School Monday to Thursday from 8:30 a.m. to 12:00 p.m. SYH offers evaluations of injuries, illness and other health concerns as well as provide health education and sports physicals. If you do not have a family doctor, SYH can also refer you and your child to one of the clinics in the immediate area for ongoing medical/dental care services.

In order to provide medical services to your son or daughter during school hours, we need your permission. Please complete and sign the attached consent and release forms and return them to the school office. In addition to allowing San Ysidro Health to provide medical care to your child, the consent form also gives the health center permission to bill your insurance company for the health care services your child receives. If your child does not have health insurance coverage, San Ysidro Health is available to assist you to apply for eligibility programs such as Medi-Cal or Healthy Families and other programs.

We will keep the consent on file in case your student becomes ill or needs to visit the clinic during the school year.

If you have questions about the health care services at San Ysidro Health school based clinic, please contact the school nurse (619) 628-3670

Respectfully,



Easter Finley
Principal
Southwest High School



Maria Carriedo, M.D.
Vice President and Chief Medical Officer
San Ysidro Health

"The Sweetwater Union School does not discriminate with regard to sex, race, religion, color, national origin, ancestry/ethnicity, marital or parental status, age, physical or mental disability, sexual orientation or any other unlawful consideration."

SUHSD Administrative Policy #2224

**Favor de regresar este paquete por correo electronico a Aileen Serrano
aileen.serrano@sweetwaterschools.org**

**SOUTHWEST HIGH SCHOOL
1685 Hollister Street. San Diego, CA 92154
(619) 628-3670
Fax: (619) 628-3770**

Estimados Padres y Estudiantes de la Preparatoria Southwest:

La Preparatoria Southwest ha colaborado con El Centro de Salud de San Ysidro y Scripps Family Medicine Residency Program para poner a disposición de los estudiantes servicios de cuidado de salud primaria en la escuela. Nuestra colaboración ha mantenido una clínica de medicina ubicada en la escuela de Southwest desde 2007.

La clínica ofrece a los estudiantes cuidado médico y ayuda a familias a inscribirse en programas de cobertura médica como Medi-Cal, Healthy Families y otros programas similares.

El equipo médico de Scripps y de San Ysidro Health está disponible en la Preparatoria Southwest de Lunes a Jueves de 8:30 a.m. a 12:00 p.m. Ofrecemos una variedad de servicios de cuidado médico como evaluaciones de lastimaduras, enfermedades y otras preocupaciones médicas y preveremos educación de salud y exámenes médicos para deportes. Si usted no tiene un médico primario, la clínica de San Ysidro Health le podrá hacer una referencia a una de sus clínicas cercanas para cuidado médico/dental continuo.

Para poder proveerle servicios médicos a su hijo/a durante el horario escolar, necesitamos su consentimiento. Por favor llene y firme el formulario adjunto de consentimiento y el formulario de renuncio de reclamación y entréguelo a la oficina de la escuela. Además de permitirle a San Ysidro Health proveerle servicios médicos a su hijo/a, este formulario de consentimiento también prmitirá que la clínica le cobre a su seguro médico por servicios médicos que reciba su hijo/a. Si su hijo/a no tiene seguro médico la clínica le puede ayudar a aplicar a programas como Medi-cal, Healthy Families y otros programas similares.

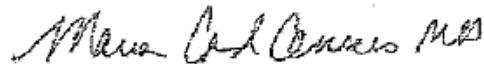
Nosotros mantendremos archivado este consentimiento en caso de que su hijo/a se enferme o necesite visitar la clínica durante el año escolar.

Si tiene preguntas acerca de los servicios médicos disponibles en la Clínica de San Ysidro Health ubicada en la escuela, favor de llamar a la enfermera de la escuela al (619) 628-3670.

Respetuosamente,



Easter Finley
Principal
Southwest High School



Maria Carriedo, MD.
Vice President and Chief Medical Officer
San Ysidro Health

"El distrito Escolar de Sweetwater High School no discrimina con respecto a sexo. Raza, religión, color, origen nacional, ascendencia/etnicidad, estado mental, edad. Incapacidad, orientación, o cualquier otra consideración ilegal"

SUHSS Póliza administrativa #2224

**San Ysidro Health
Southwest High School Student Health Clinic
Sweetwater Union High School District
1685 Hollister Street
San Diego, California 92154
(619) 628-3670**

PARENT/LEGAL GUARDIAN CONSENT FORM

Student Name: _____		Grade: _____	
Address: _____		Zip Code: _____	
Social Security Number: _____	Birth Date: _____	Age: _____	
Race: _____	Sex: _____		
Parent/Guardian Name: _____		Daytime Phone: _____	
Emergency Contact: _____	Relationship: _____	Phone _____	
Serious Illnesses: _____		Medications taken regularly: _____	
Family income (yearly): \$ _____		Number of family members: _____	

I have read and understand the health services offered at Southwest High School as described below. I understand further that the services authorized by my signature on this form are simple, common or routine health care services and treatment will be limited to:

Diagnosis and treatment of minor and acute illness, first aid for minor injuries, physical examinations, general assistance with chronic (ongoing) illnesses such as asthma, seizure disorder, diabetes, acne, immunizations, TB test, Hemoglobin, vision and hearing screening, counseling services, prescription and over the counter medicine, diet and weight control programs/nutrition counseling, family planning information and referrals, referrals for health care services which cannot be provided at the School Clinic such as laboratory and x-ray services.

I understand that this consent covers only those services provided at the clinic, and does not authorize services rendered at any other private or public facility.

I hereby authorize a physician and other professional staff to provide necessary and/or advisable treatment for my son/daughter. This student has my permission to receive all services offered on School grounds EXCEPT those which I have specifically excluded above.

I understand that students are registered directly with the San Ysidro Health when receiving care on School grounds and this will make it easier if we choose to go to a San Ysidro Health Center clinic for additional services not available at the school clinic, such as dental care and immunizations.

Medical records will be kept in a confidential manner, however, I acknowledge that the San Ysidro Health may release information regarding treatment to third party payers such as Medi-Cal, Healthy Families or insurance companies for the purpose of billing and for any reason in accordance with acceptable medical practice pursuant to law.

Signature of Parent/Legal Guardian _____	Date _____
Student's Signature _____	Date _____

If your child has Medi-Cal or Healthy Families, please complete the following information:

ID Number: _____	Enrollee Name: _____
Effective Date of Coverage: _____	

If your child has private insurance, please complete the following information:

Name of Insurance: _____	Enrollee Name: _____
ID Number: _____	Effective Date of Coverage: _____

"Sweetwater Union High School District no discrimina en cuanto a género, raza, religión, color, origen nacional, ascendencia étnica, estado civil, edad, discapacidad física o mental, orientación sexual o cualquier otra consideración ilegal." Política #2224 del consejo del SUHSD

San Ysidro Health
Clínica para estudiantes de la Escuela Preparatoria Southwest
Distrito Escolar Sweetwater
1685 Calle Hollister San Diego, Ca 92154
Teléfono (619) 628-3670

Formulario de Consentimiento del Padre o Tutor Legal

Nombre del alumno: _____		Grado: _____
Domicilio: _____		Código Postal: _____
Número de Seguro Social: _____	Fecha de Nacimiento: _____	Edad _____
Raza: _____	Genero: _____	
Padre o Tutor: _____		Teléfono diurno: _____
Caso de urgencia llame: _____	Parentesco: _____	Teléfono: _____
Enfermedad seria: _____		Medicamento que toma regularmente: _____
Ingresos familiares (anual): \$ _____		Número de miembros de la familia: _____

He leído y entiendo la clase de servicios ofrecidos en Southwest High School Heath Clinic descritos abajo: Además tengo entendido que los servicios autorizados con mi firma en este formulario son sencillos, comunes o servicios de cuidado rutinario de la salud y se limitara a:

Diagnóstico y tratamiento de enfermedades agudas, primeros auxilios por heridas menores, examen físico, ayuda general con enfermedades crónicas como asma, ataques, diabetes, acné, vacunas, prueba general del oído, vista, servicios psicológico, (incluyendo servicios de salud mental), receta para medicinas y medicamentos sobre el mostrador, programas de control de peso y nutrición, servicios y información sobre planeación familiar y referencia para servicios de cuidados de salud que no puedan proporcionarse en la Clínica de la Escuela como los servicios de laboratorio y radiología.

Entiendo que este consentimiento solo cubre los servicios proporcionados en la clínica, y no autoriza servicios otorgados en ninguna otra instalación, ya sea privada o pública.

Por consiguiente, autorizo a un médico u otro personal profesional que provean el tratamiento necesario o recomendable a mi hijo(a). Este alumno(a) tiene mi autorización para recibir los servicios que ofrece la Clínica escolar.

Entiendo que los estudiantes están registrados directamente con San Ysidro Health cuando reciben atención en la escuela y esto hará que sea más fácil si elegimos ir a una clínica de San Ysidro Health para obtener servicios adicionales que no están disponibles en la clínica escolar, como atención dental y vacunas.

Los expedientes médicos se guardarán en forma confidencial, sin embargo, reconozco que San Ysidro Health puede liberar información sobre tratamiento a terceros como Medi-Cal, Familias Saludables, o compañías de seguros con el propósito de cobrar o por cualquier razón de acuerdo y aceptable a la práctica médica de acuerdo a la ley.

Firma de los padres o tutor legal _____	Fecha: _____
Firma del alumno(a): _____	Fecha: _____

Si su higo (a) tiene Medi-Cal o Familias Saludables, favor de proveer la siguiente información:

Número de identificación: _____	Nombre del inscrito: _____
Fecha efectiva de aseguranza: _____	

Si su hijo(a) tiene otro médico/proveedor, favor de proveer la siguiente información:

Nombre del seguro: _____	Nombre del inscrito: _____
Número de identificación: _____	Fecha efectiva de aseguranza: _____

“Sweetwater Union High School District no discrimina en cuanto a género, raza, religión, color, origen nacional, ascendencia étnica, estado civil, edad, discapacidad física o mental, orientación sexual o cualquier otra consideración ilegal.” Política #2224 Del consejo Del SUHSD

**San Ysidro Health Providing Primary Care Services
At
Southwest High School**

PARENT/LEGAL GUADIAN RELEASE AND WAIVER OF CLAIMS

I (Parent/Legal Guardian Name) _____, hereby release Sweetwater Union High School District (District) and waive any and all claims for injury, accident, illness, death, or property damage occurring by reason of referral made by the District to San Ysidro Health school based clinic at Southwest High School, except for claims based upon the fraud, willful injury to person or property, or violations of law by the District, its officers, employees and agents. I further agree to indemnify the District, its officers, employees and agents from and against any and all claims, demands, losses, or liabilities or any kind or nature I may have against the District, its officers, agents and employees, sustained as a result of, arising out of, or in any manner connected with the referral to San Ysidro Health clinic, including but not limited to acts of the physician or other practitioner. I understand that San Ysidro Health is not affiliated with the Sweetwater Union High School District even though the San Ysidro Health clinic is operated on the grounds of the Southwest High School.

Signature of Parent/Legal Guardian

Date

RELEASE OF PUPIL RECORDS

I (Parent/Legal Guardian Name) _____ hereby authorize the release of records maintained by the Sweetwater Union High School District pertaining to my child (Name of Student) _____ to San Ysidro Health ("SYH") as requested by SYH for purposes of providing services at the SYH medical clinic located at the Southwest High School , or to any SYH medical clinic , provides that SYC maintains the confidentiality of those records and does not release them to a third party without my further written consent.

Signature of Parent/Legal Guardian

Date

" The Sweetwater Union School does not discriminate with regard to sex, race, religion, color, national origin, ancestry/ethnicity, marital or parental status, age, physical or mental disability, sexual orientation or any other unlawful consideration."

SUHSD Administrative Policy #2224

**Centro de Salud de San Ysidro Proveyendo Servicios Medicos
en la
Preparatoria Southwest**

FORMULARIO DE RENUNCIO DE RECLAMACION PARA PADRE O TUTOR LEGAL

Yo (padre o tutor legal) _____, por medio del presente documento libero al Distrito de Sweetwater Union High School (Distrito) y renuncio a toda reclamación por accidente, enfermedad, muerte o daño a propiedad que haya tenido lugar por ser referido por el distrito a la clínica del Centro de Salud de San Ysidro localizada en la escuela Southwest con la excepción de reclamaciones en fraude, daño voluntario a personas o propiedad, o violaciones de la ley por el Distrito, sus oficiales, empleados o agentes. Además, estoy de acuerdo en indemnizar el distrito, sus oficiales, empleados o agentes contra cualquier reclamo, demanda, pérdidas u obligaciones, o de cualquier clase o naturaleza que puede tener en contra del Distrito, sus oficiales, agentes, sufridos como resultado de, o a causa de, o conectado en cualquier forma con la recomendación (referral) al Centro de Salud de San Ysidro, incluyendo, pero no limitándose a actos del médico u otro profesional. Estoy consciente, que aun cuando la clínica del Centro de San Ysidro se localiza en la escuela Southwest no está afiliada el Distrito de Sweetwater Union High School

Firma del Padre o tutor legal

Fecha

AUTORIZACION PARA OBTENER ARCHIVOS DEL ALUMNO

Yo (padre o tutor legal) _____ autorizo la liberación de los expedientes mantenidos por el Distrito de Sweetwater Union High School de mi hijo: _____ en la clínica de San Ysidro health, solicitados por parte del Centro de Salud con el propósito de proveer servicios en el programa de la clínica medica del centro de Salud de San Ysidro en la escuela Southwest o en cualquier clínica del Centro de salud, a condición que el centro de Salud de San Ysidro mantenga en confianza esos expedientes y no los libere a terceras partes sin mis consentimiento adicional por escrito.

Signature of Parent/Legal Guardian

Date

“El distrito Escolar de Sweetwater High School no discrimina con respecto a sexo. Raza, religión, color, origen nacional, ascendencia/etnicidad, estado mental, edad. Incapacidad, orientación, o cualquier otra consideración ilegal”

SUHSS Póliza administrativa #2224

Over-The-Counter (OTC) Medication Authorization Form

Student Name: _____ Date of Birth: _____ Grade: _____
Last First

Medication Allergies: No _____ Yes _____ If Yes, give name of medication(s): _____
Describe reaction: _____

OTC Medications students may take while at school will be provided by the school nurse. Medications may be added or deleted from this authorization form at any time during the school year by contacting the School Nurse. With parental consent, the following types of OTC medications may be made available to your child when needed.

Please check "yes" to authorize school nurse/staff to give your child the following medications while on campus. *OTC medications are dispensed per package directions unless written directives are provided by a physician.*

Over-the-counter medication dispensed <i>per package</i> directions:	Indications:	Yes
Acetaminophen (Tylenol) or generic	Pain reliever/fever reducer	
Cough drops or throat lozenges	Cough/throat irritation	
Calcium Carbonate (Tums)	Stomach Pain	
Ibuprofen (Advil) or generic	Pain Reliever/fever reducer	

Please add any other OTC medications you expect to provide for your child. Do not list prescription medications in this location. An authorization form from a physician is required for prescriptions. .
All medications brought to campus must be checked in with the School Nurse and listed on this form.

Over-the-counter medication dispensed <i>per package</i> directions:	Indications:	Yes

I give permission for medication(s) listed above to be given to my child for self-administration at the Nurse's discretion or dispensed by designated personnel as delegated by the School Nurse.

Parent Signature _____

Date _____

Formulario de autorización para medicamentos que no requieren receta médica

Nombre del alumno: _____ Fecha de nacimiento: _____ Grado: _____
Apellido Nombre

Alergias a medicamentos: No _____ Sí _____ Si contestó que sí, escriba el nombre del medicamento _____

Describa la reacción: _____

La enfermera del plantel está a cargo de suministrar todo medicamento que no requiere receta médica. En cualquier momento durante el ciclo escolar se pueden agregar o eliminar medicamentos del formulario de autorización sólo necesita hablar con la enfermera de la escuela. Con la autorización de los padres, se le podrán administrar a su hijo (a) los siguientes medicamentos que no requieren receta médica.

Por favor marque "sí" para autorizar a la enfermera o al personal de la escuela a administrarle a su hijo (a) los siguientes medicamentos en la escuela. *Dichos medicamentos se administran siguiendo las instrucciones que aparecen en el producto a menos que el médico indique por escrito lo contrario.*

Medicamentos que no requieren receta médica que se administran de acuerdo a las instrucciones que aparecen en el producto:	Indicaciones:	Sí
Paracetamol o acetaminofén (<i>Tylenol</i>) o producto genérico.	Alivia el dolor y disminuye la fiebre.	
Pastillas para aliviar la tos o pastillas para la garganta.	Tos e irritación de la garganta.	
Carbonato de calcio (<i>Tums</i>).	Dolor de estómago.	
Ibuprofeno (<i>Advil</i>) o producto genérico.	Alivia el dolor y disminuye la fiebre.	

Favor de agregar otros medicamentos que no requieren receta médica, y que usted espera que le proporcionemos a su hijo (a). No incluya medicamentos que requieren receta médica en el espacio a continuación. *Todo medicamento que introduzca al campus debe ser revisado por la enfermera e incluido en el presente formulario.*

Medicamentos que no requieren receta médica que se administran de acuerdo a las instrucciones que aparecen en el producto:	Indicaciones:	Sí

Autorizo que la enfermera de la escuela o personal asignado por la misma proporcione a mi hijo (a) los medicamentos que aparecen en la lista para que mi hijo (a) se los auto administre.

Firma del padre o de la madre _____

Fecha _____

"El distrito Escolar de Sweetwater High School no discrimina con respecto a sexo, Raza, religión, color, origen nacional, ascendencia/etnicidad, estado mental, edad. Incapacidad, orientación, o cualquier otra consideración ilegal"

SUHSS Póliza administrativa #2224

Sports/Co-curricular Participation Screening Risk Assessment

STUDENT NAME: _____ BIRTHDATE: _____

SCHOOL: _____ GRADE: _____

SPORT(S): _____ GENDER: ☐ Male ☐ Female ☐ Non-Binary

ADDRESS: _____ HOME PHONE: _____

FATHER'S WORK PHONE: _____ FATHER'S CELL PHONE: _____

MOTHER'S WORK PHONE: _____ MOTHER'S CELL PHONE: _____

FAMILY DOCTOR: _____ DOCTOR'S PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT HOME/CELL PHONE: _____

MEDICAL HISTORY - Please answer the following questions regarding your student. Please explain "YES" answers below.

1	Has or had injuries requiring medical attention?	☐ Yes	☐ No
2	Has or had an illness requiring hospitalization?	☐ Yes	☐ No
3	Has or had coughing, wheezing, or trouble breathing during or after activity?	☐ Yes	☐ No
4	Has or had asthma?	☐ Yes	☐ No
5	Have had seasonal allergies that require medical treatment?	☐ Yes	☐ No
6	Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	☐ Yes	☐ No
7	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐ Yes	☐ No
8	Have you ever passed out during or after exercise that require medical treatment?	☐ Yes	☐ No
9	Have you ever been dizzy during or after exercise that require medical treatment?	☐ Yes	☐ No
10	Have you ever had chest pain during or after exercise that require medical treatment?	☐ Yes	☐ No
11	Have you ever had racing of your heart or skipped heartbeats that require medical treatment?	☐ Yes	☐ No
12	Have you ever been told you have a heart murmur?	☐ Yes	☐ No
13	Have you ever been told you have high blood pressure? * NO CAFFINATED DRINKS 4 HOURS PRIOR TO SCREENING*	☐ Yes	☐ No
14	Has any family member or relative died of heart problems or of sudden death before age 55?	☐ Yes	☐ No
15	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐ Yes	☐ No
16	Have you ever had a head injury or concussion, been knocked out, become unconscious, or lost your memory?	☐ Yes	☐ No
17	Have you ever had a seizure?	☐ Yes	☐ No
18	Do you have frequent or severe headaches that require medical treatment?	☐ Yes	☐ No
19	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	☐ Yes	☐ No
20	Have you ever had a stinger, burner, or pinched nerve?	☐ Yes	☐ No
21	Is hearing impaired, and/or has glasses/contact lenses? **MUST BRING CONTACTS/GLASSES TO SCREENING**	☐ Yes	☐ No

Please explain any "YES" responses: _____

I have reviewed this medical history. In case of injury I hereby give consent for my son/daughter to have initial first aid administered by school personnel in charge and to be transported to a doctor or hospital for further treatment if necessary.

Parent/Guardian Signature _____

Date _____



Sweetwater Union High School District

1130 Fifth Avenue, Chula Vista CA 91911 619-585-6015

Parent Consent

STUDENT NAME: _____ **SCHOOL:** _____

SPORT(S): _____ **GENDER:** Male Female Non-Binary

I hereby give my consent for my student _____ to be given a Sport/ Co-curricular Participation Screening Examination and (if indicated an EKG/ECHO CARDIOGRAM/ Baseline Concussion Testing) by a team of Sports Medicine Specialists (Orthopedic Surgeon, Family Practitioner, Certified Athletic Trainer and Physical Therapist).

Parent/Guardian Signature _____

DATE _____

PHYSICAL EXAM

Height:	_____	Weight:	_____
Blood Pressure*:	_____	Pulse:	_____
Vision (R):	_____	Vision (L):	_____
Flexibility/Posture:	<u>Normal</u>	<u>Abnormal</u>	
ROM Screens:			Blood Pressure RE-CHECK*:
Upper Extremities	_____	_____	2 nd _____
Lower Extremities	_____	_____	3 rd _____
Scoliosis	NO	YES	
Comments:	_____		

ORTHOPEDIC EXAMINATION

<u>Upper Extremities</u>			<u>Lower Extremities</u>		
	<u>Normal</u>	<u>Abnormal</u>		<u>Normal</u>	<u>Abnormal</u>
Shoulder	_____	_____	Hip	_____	_____
Elbow	_____	_____	Knee	_____	_____
Wrist/Hand	_____	_____	Ankle	_____	_____
Spine	_____	_____	Foot	_____	_____
Comments:	_____				

ORTHOPEDIC DETERMINATION - In my opinion this student (please check one):

☐ Is CLEARED for sports/co-curricular participation ☐ Is NOT-CLEARED for sports/co-curricular participation ☐ Ortho Deferred

Ortho Physician: _____ MD /DO Date of Physical: _____

PHYSICAL EXAMINATION

	<u>Normal</u>	<u>Abnormal</u>		<u>Normal</u>	<u>Abnormal</u>	
Head & Neck	_____	_____	Cardiovascular	_____	_____	Female - Age of 1 st menstrual cycle: _____
Eyes	_____	_____	Gastrointestinal	_____	_____	
Ears/Nose & Throat	_____	_____	Genito-Urinary	_____	_____	

Comments: _____

PHYSICIAN DETERMINATION In my opinion this student (please check one):

☐ Is CLEARED for sports/co-curricular participation ☐ Is NOT-CLEARED for sports/co-curricular participation ☐ Medical Deferred

Physician: _____ MD /DO Date of Physical: _____

EKG/ECHO REFERRAL: ☐ Is CLEARED if EKG is within NORMAL limits.

☐ EKG completed & within NORMAL limits? YES NO ☐ Cardiac Deferred

EKG/ ECHO Comments: _____

Comments on Medical History: _____

NOTE: Hospital, Clinic or Doctor's Stamp
REQUIRED