CONEJO VALLEY UNIFIED SCHOOL DISTRICT
2027-2028
Student Health Inventory

Name: _____ _____ _____ Date: _____
(last) (first) (middle)

Birthdate:_____Gender: ☐ Male ☐ Female ☐ Non-Binary Grade in 2027-2028: _____

Medications needed at school, including emergency/allergy medication require a physician-signed, school- provided medication authorization (CVUSD Administrative Regulation 5141.21). Please identify and describe any health problems, chronic illnesses, serious injuries, or special medical needs below.

☐ Asthma
☐ Allergies (see below)
☐ Convulsive Disorder (epilepsy/seizures)
☐ Diabetes
☐ Frequent Headaches
☐ Hearing Impairment
☐ Heart Condition
☐ Kidney Problems
☐ Orthopedic Problem
☐ Speech Impairment
☐ Vision Impairment
☐ Other:

1. List any serious or life-threatening allergies to drugs, food, insect stings: _____

   _____

2. List daily and/or emergency medications taken at home: _____

   Reason: _____

3. List daily and/or emergency medications taken at school: _____

   Reason: _____

4. Identify any other health problems: _____

5. Has your child ever sustained a head concussion? _____ Date of concussion: _____

Communicable Diseases: Please give date if child has had any of the following:

_____Chicken Pox _____Mumps _____Rubella/German Measles
_____Measles _____Rheumatic Fever _____Tuberculosis

AUTHORIZATION FOR TREATMENT: In the event of an emergency requiring immediate medical attention, I hereby authorize the Conejo Valley Unified School District to obtain emergency transportation and treatment on my child's behalf. The undersigned authorizes the hospital to provide appropriate treatment. I understand that every effort shall be made by the hospital to contact the parent or guardian prior to any treatment, but treatment shall not be withheld if the parent or guardian cannot be reached. **I also understand that the Conejo Valley Unified School District does not assume any financial responsibility for medical care or ambulance transportation.** These authorizations and permissions shall be and remain in full force and effect for the current school year unless revoked in writing. I also understand that I should contact the school immediately if there are any changes in the information contained on this sheet.

Physician's Name:_____Phone Number: _____

Vision and Hearing Screenings

These are required at specific intervals and grade levels in California. Schools must conduct vision screening on all students upon school entry and every third year thereafter through grade eight. For example, vision testing may be done in kindergarten or first grade and in grades two, five, and eight, as well as on enrollment and referral at any grade level. Hearing screening is mandated in kindergarten/first grade and in second, fifth, eighth, tenth/eleventh grade and upon first school entry (California Code of Regulations, Title 17, Section 2952 (c)(1)) .

I approve of having periodic health screening for my child, as mandated by California Education Code, which includes vision and hearing.

Parent/Guardian Initials:

Complete and return to your school office.

CONEJO VALLEY UNIFIED SCHOOL DISTRICT
2027-2028

Medical Emergency Authorization

I hereby give permission for my son/daughter to receive emergency medical care, routine health screenings, and authorize the release of any information on this document to authorized school employees, first responders, and/or the Health Department upon request. I give consent to those agents pursuant to the provision of Family Code Section 6910.

Parent/Guardian Initials: _____

Insurance Company:	
Member ID:	
Group ID:	
Primary Card Holder First Name:	
Primary Card Holder Last Name:	
Primary Card Holders Date of Birth	
Primary Card Holder Relationship:	

Authorization to Bill for Mental Health and Wellness:

As part of our continued efforts to expand access to high-quality, school-based behavioral health services, the Conejo Valley Unified School District is requesting formal authorization to bill eligible mental health and wellness services under the Children and Youth Behavioral Health Initiative (CYBHI).

For more information please visit our CVUSD Mental Health webpage at:
https://www.conejousd.org/departments-services/student-services/mental-health-and-wellness-services

Children Youth Behavioral Health Initiative (CYBHI) Fee Schedule

Through the CYBHI fee schedule, schools and affiliated providers can receive revenue for behavioral health and wellness services, including screening, assessments, and ongoing support given to students. **Payments for services will come directly from the insurance companies, at no cost to the parents or caregivers**. This program will not affect insurance coverage (i.e., no copays, no higher premiums, or deductibles). Receiving services at school will not reduce or impact a student's or their family's ability to obtain care outside of school.

Request for Student Health Insurance Information

Schools across California are now regularly collecting medical insurance information from students and families to participate in the CYBHI Initiative. Doing so will allow the school to continue to provide behavioral health and wellness support to students and to improve access to essential care and services. Insurance information shared with your child's school will be used to verify coverage and eligibility. All health information will be stored securely and shared only in compliance with federal and state laws.

Consent To Treat

The District offers free mental and behavioral health services at school through California's Children and Youth Behavioral Health Initiative (CYBHI). These include individual or group counseling, skill-building, social-emotional groups, anger or grief support, check-ins, assessments, care coordination, referrals to community resources, and telehealth (video/phone) when appropriate—all provided by

school staff (like counselors, psychologists, social workers, nurses) and community partners, with some services by supervised trainees. There are no out-of-pocket costs or co-pays for families, though health insurance (Medi-Cal or private plans) may be billed if applicable; refusing or withdrawing consent won't affect your child's free public education, special education rights, or school access. Participation is voluntary—you (or your child aged 12+ for certain services like mental health or substance use counseling) can revoke consent in writing anytime, with the form valid for one year unless revoked earlier. Privacy is protected under FERPA, HIPAA, and California laws—we share only the minimum necessary information for treatment, care coordination, basic school support (like appointment reminders or class excusals on a need-to-know basis), program evaluation, or required reporting (e.g., safety risks or suspected abuse); detailed therapy notes or certain substance use records need extra permission. You have rights to view/correct records, request confidential communication, limit sharing where possible, and contact your child's school with questions or concerns.

Consent To Treat Document can be found at https://www.conejousd.org/.

Consent To Treat:	
Consent To Treat Completed By:	
Consent To Treat Signed By:	
Consent To Treat Date Completed:	

Data Privacy and Security

Student health records will be shared by the school district with the statewide claims database through a system that is secure, encrypted, and complies with all regulatory requirements. All information obtained is protected under the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule protects sensitive patient health information from being disclosed without the patient's consent or knowledge.

Notice of Privacy Practices Document can be found at https://www.conejousd.org/.

Consent To Bill

I authorize the Consortium Lead/SD to bill Medi Cal, commercial, or private insurance for social emotional, mental, and/or behavioral health services provided to myself or my child/dependent. Families will not be charged out of pocket costs for services delivered at school under CYBHI. Refusing or withdrawing consent will not affect your or your child's access to these services. This consent is valid for one year from the date signed unless revoked earlier in writing.

Consent To Bill Document can be found at https://www.conejousd.org/.

Consent To Bill:	
Consent To Bill Completed By:	
Consent To Bill Signed By:	
Consent To Bill Date Completed:	

Complete and return to your school office.