Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Grade: \_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Parents and/or Guardians Name and Phone #’s:**

 Mother/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **In the event we cannot reach you, whom may we contact?**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

 Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Dental visit/cleaning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete all information, even if it has not changed from last year! Please notify us of any changes as they may occur during the school year.**

**Please be advised that in an emergency situation, the nearest hospital will be used.**

**In the event of an emergency, do you give Lamar School Staff permission to obtain medical services for your child? Yes No (please circle)**

**Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\*Please see front and back\***

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** (Please list all and the type of reaction your child has)

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bee or Wasp or Insect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any **illness** your child may have: **ADD ADHD PTSD**

**ASTHMA CANCER DIABETES HEARING LOSS/AID(S)**

**BLEEDING DISORDER RESPIRATORY HEART SEIZURE DISORDER**

**DEVELOPMENTAL CELIAC HEARING LOSS VISION LOSS**

**OTHER \* (or be specific about any of the above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list all **medications**, dosages, and times that your child takes on a daily basis:

Please **cross out or circle** any medications you  **DO NOT** want your child to receive!

**Tylenol Tums/Antacid Cough Drops Benadryl Antibiotic Ointment Caladryl Lotion Peroxide Chloraseptic spray Antifungal cream Orajel Lip Balm Ibuprofen Sun Screen (sensitive) Aloe Vera Gel Insect Sting Swab First Aid/Burn Cream Tussin CF or Sudafed (4th thru 12th grade) Pepto Bismol (4th thru 12th Grade)**

**I, Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

give my permission for licensed or trained unlicensed personal to administer the above medications to my child on an as needed basis. Your child will bring home a note showing what they were given and when.

**\***May use additional paper if necessary

**\*\*Separate consent form required for daily medications or inhalers or epi pens**.

**\*\*\*Please see separate sheet for student athletes.**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please be advised that the school nurse CANNOT give any student Benadryl if they are 5 years old or less without a written doctor’s order. Please indicate on page 2 if Benadryl makes your child sleepy/hyper. It is our policy to call parents before administering Benadryl to a student.**

**Any change in a student’s meal plan, new allergies, or medication changes or new diagnosis cannot be done without a written order from their doctor. If you will call us, we will provide the appropriate paper work needed to meet state mandates or you can sign a release of information form giving us permission to fax their family doctor directly.**

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance (Please provide a copy of the insurance card)**

Circle Type of Insurance: Medicaid ARKids Private Ins. None

Please provide your insurance Number below:

Medicaid #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARKids # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pvt Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lamar School Nurse’s:**

**Karma Williams RN – District RN 479-885-3965**

**Shelley Boswell LPN – High School & Middle School 885-0052 & 885-3914**

**Doty Torres LPN – Elementary School & ABC Program 885-2389 & 885-3289**

**\*Please see front and back\***

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS and**

**LAMAR SCHOOL DISTRICT #39**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including FERPA/HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. **This will facilitate sharing information with Primary Care Provider or Health Management Organization.**

**USE AND DISCLOSURE INFORMATION:**

Patient/Student Name: **­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Last First MI 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:

 Lamar School District #39 635 Childers Ave., Lamar, AR, 72846

School District to which disclosure is made Address / City and State / Zip Code

 Registered Nurse 479-885-3965

 Contact Person at School District Area Code and Telephone Number

 The disclosure of health information is required for the following purpose: Continuity of care

 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 08/31/15 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 obtains 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 anytime. 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 will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA). 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:**

 Printed Name Signature Date

 Relationship to Patient/Student Area Code and Telephone Number

Dear Parent/Guardian:

The district’s School Health Services program supports your student’s academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as **Mandated (required) by the State** **of Arkansas**. During this school year, the following screenings will be required (bold) or completed at school:

**Vision**

* Distance acuity for all newly entering students and students in Pre-K, Kindergarten, Grades 1, 2, 4, 6, 8 and 10.
* Near vision acuity and color perception screening for all newly entering students and students in Grades 1, 2, 4, 6, 8 and 10.
* Please submit a copy of eye exam’s done in the last 3 to 6 months.

**Hearing**

* Hearing screening for all newly entering students and students in Pre-K, Kindergarten, Grades 1, 2, 4, 6, 8 and 10. If your child wears hearing aids or is deaf, please send last exam to us for our records.

**Scoliosis**

* Scoliosis (spinal curvature) screening for girl students in Grades 6 – 8.
* Scoliosis screening for boy students in Grade 6.

**Health Appraisals**

* A physical examination including Body Mass Index and Weight Status Category Information is required for all newly entering students and students in Kindergarten, Grades 2, 4, 6, 8 and 10. **Results available upon parental/guardian request. May be refused by parent/guardian or student.**

Puberty(Hygiene)Program**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* The “Always Changing” Program to discuss puberty/hygiene. Fifth graders only. **This is not “a sex talk” nor will it be allowed to become one!**

Other grades will be done as time allows or requests are made by parents or staff, except the Puberty Program. A letter will be sent home if there are any findings on the screening done at school that would cause concern or need medical follow-up. Please call the school’s Health Office (479-885-3965) if you have any questions or concerns.

**Please sign consent forms and release of information forms.**

By signing below, you are **consenting** to all screenings. If you **do not** want your child to participate in Health Appraisal testing or Puberty program, please place **xxx’s** through that test or program.

Childs Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lamar School Nurses

Karma Williams, RN, Shelley Boswell, LPN and Doty Torres, LPN

\***Please sign front and back\***

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN REQUESTOR and**

**LAMAR SCHOOL DISTRICT #39**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including FERPA/HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

**USE AND DISCLOSURE INFORMATION:**

Patient/Student Name: **­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Last First MI Date of Birth

I, the undersigned, do hereby authorize: Lamar School District #39

to provide health information from the above-named child’s medical record to and from:

 Third Party Biller 301 Elberta St, Lamar, AR 72846

 Requestor Address / City and State / Zip Code

 Lamar School District #39 479-885-3907

 School District Area Code and Telephone Number

 The disclosure of health information is required for the following purpose:

 **Reimbursement for state mandated screenings**

Requested information shall be limited to the following:

 All minimum necessary health information; or

x

 Disease-specific information as described:

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DURATION:** This authorization shall become effective immediately and shall remain in effect until June 15, 2015 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 obtains 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 anytime. 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 will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA). 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:**

 Printed Name Signature Date

 Relationship to Patient/Student Area Code and Telephone Number