WHITMAN-HANSON REGIONAL SCHOOL DISTRICT
ANNUAL STUDENT HEALTH UPDATE FORM

STUDENT NAME: _____
Last *First* *Middle*

DOB: (MM/DD/YYYY) _____School: _____ Grade: ____ Teacher: _____
Name of Physician: _____ Phone: _____
Name of Dentist: _____ Phone: _____
Health Insurance Provider _____ □ Private □ Mass Health/Medicaid □Other

HEALTH INFORMATION:

Does your child have any of the following? Please check if YES and explain:

□Allergies _____ Type of Reaction_____ Epi Pen □Yes □No
□Asthma _____ □Heart Problems _____
□Kidney Problems _____ □Diabetes_____
□Seizures_____ □Scoliosis_____
□Mental Health Issues _____ □Physical Disability _____
□Intellectual/Cognitive Disability _____ □Concussions _____
□Hearing Problems_____ Hearing Aides □Yes □No
□Vision Problems _____ □Glasses □Contacts
□Other Health Concerns _____
_____
_____

Does your child take any medication? □ Yes □ No If Yes please list medication and reason: _____
_____
_____
_____

**Any medications that need to be given by the school nurse during the school day require a physician's order and a parent medication administration consent form.*

PERMISSION FOR OVER THE COUNTER MEDICATION:

I give the school nurse permission to administer the following medications as per the standing orders authorized by the WHRSD school physician:

Tylenol □Yes □No **Ibuprofen** □Yes □No **Tums** □Yes □No **Benadryl** (for allergic reaction) □Yes □No

- **Parent/Guardian signature**: _____ Date: _____

PARENT/GUARDIAN CONSENTS:

Sharing of Health Information

I give permission to the school nurse to share the above medical information with school personnel as determined appropriate for my child's health and safety? □**Yes** □**No** If only certain information can be shared, please explain_____

Release of Information

I give the school nurse permission to contact my child's primary health care physician, when appropriate, for a 2 way exchange of medical information in order to meet the health and safety needs of my child. I understand I will be contacted prior to this communication. □**Yes** □**No**

Permission for Treatment

In the event of a serious illness/injury, I hereby authorize the school to contact my child's physician and/or seek emergency medical care including transportation to a medical facility. I hereby authorize the physician and emergency room staff to administer care that is deemed necessary. I understand that every effort will be made to contact the family and emergency contact first. □**Yes** □**No**

- **Parent/Guardian Signature** _____ Date: _____
- Print Name: _____ Relationship: _____

Additional Information/Releases:

If you have no health insurance, the Commonwealth of Massachusetts has a health insurance plan that will provide uninsured children with affordable health care (restrictions may apply). If you are interested in more information about this program, please contact the school nurse.

***Consent for Release of Information to Access Medicaid Reimbursement for Health-Related Support Services:**
Our school district continues to participate in a system whereby the Federal Government's Medicaid program reimburses local school districts for a portion of the costs of health-related special education services provided to Medicaid-eligible children. Your child continues to receive services at no cost to you under this system. This initiative simply helps us optimize federal funds in support of local education, as well as offset some of the costs of special education paid for by the local taxes. The information you voluntarily allow to be released by completing this consent form will only be used for the purposes identified. Our district has contracted the services of MSB™ to confidentially administrate our Medicaid Program.

As parent/guardian of the child named above, I give permission to disclose personally identifiable information concerning health-related support services in my child's present and/or future Individualized Education Plan (IEP) to school districts and designees, State, and Federal Medicaid administration representatives for the sole purpose of claiming MEDICAID reimbursement. I understand and agree that the School District may access my or my child's Medicaid benefits to pay for health-related support services in my child's present and/or future IEP.

This permission is authorized now and in the event that my child becomes eligible in the future for purpose of the release of information relative to the above services. I also understand that if I refuse to consent to the release of this information, my refusal does not relieve the school district of its responsibility to provide the above IEP-ordered services at no cost to me (34 C.F.R. §300.154 (2013)). I also understand that this consent is voluntary and may be revoked at any time, but that such revocation would not be retroactive (34 C.F.R. §300.9 (2006)).

I consent for Release of Information to Access Medicaid Reimbursement for Health-Related Support Services. □**Yes** □**No**

Parent/Guardian Signature _____ Date _____