SAN DIEGO UNIFIED SCHOOL DISTRICT School Year _____

HEALTH INFORMATION EXCHANGE CONSENT

This form to be placed in <u>all</u> registration & annual registration update packets

Child's Name: _____ Birthdate: _____

Last First Middle Month/Day/Year

School: _____ Grade: _____ Social Security #: _____

Phone No.: ( ) _____ ( ) _____ ( ) _____

Area Code Home Area Code Work Area Code Cell

Physician's Name/Clinic: _____ Telephone #: _____ ☐ No Physician

Health Insurance Plan: _____ ☐ No Health Plan

(If Medi-Cal, Covered CA, or another health plan, please write <u>name</u> of health plan)

☐ My children **<u>do not have health insurance</u>** (example: Medi-Cal, Covered CA, private insurance) and I would like more information. Please release my name, address, and telephone number to an authorized insurance enrollment worker.

HEALTH HISTORY: Indicate known Health Problems (**give dates and details for all checked boxes in comment box below)**

☐Asthma

☐Allergies

☐Behavior/Emotional Problems i.e. ADHD

☐Diabetes

☐Heart Problem

☐Kidney Disease

☐Seizure Disorder

☐Skin Conditions

☐Ear Problem, Hearing Deficit

☐Eye Problem, Glasses

☐Operations, Fractures, Head Injury, Concussion

☐Other Health Information

Health History comments:

State law requires that the parent inform the school if a child is receiving prescribed medication for a continuing health problem. (California Education Code § 49480)

Medication: _____ Dosage: _____

There are occasions when an over-the-counter (OTC) medication may be given to students six (6) years and older.

If you would like the school nurse or other trained staff to provide to your child ibuprofen, acetaminophen, calamine lotion and/or antacids per district protocol please check: □ Yes □ No

_____ _____ _____

Parent/Guardian Signature or Authorized Representative or Minor Student | Parent/Guardian Name (print) | Date

This authorization expires at the end of each academic year and must be renewed annually.

PLEASE RETURN TOMORROW

Rev. 6/17 cm:kt

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