Form 3

Whitman-Hanson Regional School District

Student Health Information Update Form (Please Print)

Parent/Guardian: To ensure accurate response in the event of a medical issue, please complete all fields listed below.

Student's Name: _____
Last First Middle

Birth Date (MM/DD/YYYY): _____ Grade _____

MEDICAL INFORMATION

Physician Name:_____Tel #:_____Dentist Name:_____Tel#:_____

Health Insurance Provider:_____

☐ Public Insurance ☐ Private Insurance ☐ Mass Health ☐ No Insurance

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)).

Allergies: _____

Current Health Conditions: _____

PERMISSION FOR OVER THE COUNTER MEDICATIONS

If you do not consent to your student using hand sanitizer please notify the school nurse immediately.

My child has permission to receive non-aspirin medications at the discretion of the school nurse, and the standing orders authorized by the Whitman-Hanson Regional School District school physician: ☐ **YES** ☐ **NO**

RELEASE OF INFORMATION

I authorize the school nurse to contact the above physician, when appropriate, for a 2-way exchange of medical information. I understand that 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 to 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 contacts first.**

☐ **YES** ☐ **NO**

SHARING OF HEALTH INFORMATION

I give permission to the school nurse to share health information with the school personnel as determined appropriate for my child's health and safety.

☐ **YES** ☐ **NO**

Parent/Guardian Signature_____ **Date:**_____

Print Name:_____ **Relationship:**_____

OVER

Whitman-Hanson Regional School District
Student Health Information (Please Print)
Confidential Information, please return to the Health Office

Does your child have any allergies (food, bees/insects, medication, environmental)?
☐ Yes ☐ No If yes, does your child have an Epi Pen? ☐ Yes ☐ No

Please list allergies and your child's reaction and symptoms:

_____

_____

_____

Does your child have any medical/mental health conditions that health services should be aware of, such as Diabetes, Asthma, Seizures, Heart Condition, Anxiety, Depression etc.
☐ Yes ☐ No

If yes: What is the medical condition and date of diagnosis _____

Symptoms your child may have that would alert us that he/she is having a problem related to his/her condition:
_____

_____

_____

Please list any current medications:

Medication Name _____ Dose_____ Time of Dose_____

Medication Name_____ Dose _____ Time of Dose _____

Is there any other information that would be helpful for health services to know about your

child?_____

_____

_____