IUSD HEALTH SERVICES (949) 936-7520

HEALTH CONDITION INFORMATION

School: _____ Date: _____

Teacher/Counselor: _____ Grade: _____

Student's Last Name: _____ Student's First Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone Number: _____ Student's Gender: ☐ Male ☐ Female ☐ Non-binary

☐ Yes ☐ No Does this student have health insurance? **If no**, would you be interested in receiving information about possible health insurance options? ☐ Yes ☐ No

☐ Yes ☐ No Has this student ever been diagnosed with or treated for **ANY** medical conditions or health concerns? Please remember to include conditions such as allergies and genetic disorders.
If yes, please list and describe or explain the medical condition(s):

☐ Yes ☐ No Could any of these conditions affect this student's ability to participate in routine school activities or programs, either in the classroom or during physical activity?
If yes, please list and explain any medical restrictions, considerations, or special needs:

☐ Yes ☐ No Does this student require any special health procedures during the regular school day?
If yes, please list the procedures and any equipment that will be needed**:**

☐ Yes ☐ No Does this student take any prescription or non-prescription medication, either regularly or occasionally, at home or at school? **If yes,** please complete the following:

Medication: _____ Dose/time/frequency given: _____ Reason for medication: _____ For use at: ☐ home ☐ school ☐ both

Medication: _____ Dose/time/frequency given: _____ Reason for medication: _____ For use at: ☐ home ☐ school ☐ both

Medication: _____ Dose/time/frequency given: _____ Reason for medication: _____ For use at: ☐ home ☐ school ☐ both

All prescription or non-prescription medication needed at school requires a written physician order and parental consent. Medication forms are available on line at www.iusd.org.

☐ Yes ☐ No Does this student have any difficulty with vision? Student wears: glasses ☐ Yes ☐ No Contact lenses ☐ Yes ☐ No

☐ Yes ☐ No Does this student have a hearing loss Does this student wear a hearing aid? ☐ Yes ☐ No If yes: ☐ Right Ear ☐ Left Ear ☐ Both Ears

CONSENT TO SHARE INFO, MEDI-CAL BILLING

The District, in cooperation with the California Departments of Health Care Services and Education, participates in a program that allows the district to be reimbursed with federal Medicaid dollars for select health services provided to Medi-Cal Eligible students at school. In order for the district to receive reimbursement for these services, we must obtain your consent to release limited education records to the Department of Health Care Services (DHCS) and our reimbursement recovery vendor; and we must obtain your consent to access public benefits if your child is enrolled in Medi-Cal.* Records that may be shared include: child's name and date of birth, along with health-related evaluation, intervention, and referral information (for services received at school), all of which are shared securely.

☐ I **consent** to the release of my child's related health records and to access my child's Medi-Cal benefits **(if enrolled)**

☐ I **do not consent** to the release of my child's related health records or to access my child's Medi-Cal benefits **(if enrolled)**

Parent / Guardian / POA Signature: _____ Date: _____

***Note: Your consent or non-consent does not affect the services available and provided to your child and should not impact your Medi-Cal benefits.**

Please remember that any student's education can be affected by medical, developmental, or emotional conditions and it is a parent/guardian responsibility to immediately notify the school nurse of any changes in the student's health status. This information may be shared with teachers and other appropriate school personnel who care for your child. By signing below, you are affirming that the above statements are true to the best of your knowledge and giving permission for school personnel to contact the physician if needed.

Parent / Guardian / POA Signature: _____ Relationship to student: _____ Best way to reach me: Phone: _____ Email: _____

Parent / Guardian / POA Signature: _____ Relationship to student: _____ Best way to reach me: Phone: _____ Email: _____