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.
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

SDUSD participates in a program that allows the District to be reimbursed with federal dollars for selected health services provided to students at school who are eligible for Medi-Cal. This program generates funds that support some staff cost and some equipment needed to provide services. In signing, you are indicating that we have your consent to seek reimbursement from the State for Medi-Cal benefits on behalf of your child, if your child is eligible for this program or becomes eligible. There is no cost or penalty to you if you consent to this, nor if you do not consent to it. It simply gives the District the right to access additional governmental supports.
I give consent for SDUSD to release information (e.g. Student ID number, Last/First Name, Date of Birth, Sex, Student Address, Health Procedures/Screenings done at school, Health Education) about my child's participation in health assessments for the sole purpose of Medi-Cal billing. □ Yes □ No

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

Rev. 4/16 cm:kt
PS # 2059

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