<Insert School Name>

**HEALTH SERVICES FORM 2013-14**

**Please fill out this entire form. This information will be kept confidential.**

**Student's Legal Name:**

Last _____ First _____ Middle_____

Date of birth _____/_____/_____ Social Security Number _____-_____-_____

Student's Address _____ Apt. _____ Zip Code _____

**Contact Person**

Last Name _____ First Name _____ Relation _____

Address _____ Apt. _____ Zip Code _____

Does the student reside at this address? _____ (Y/N) Phone Numbers: Home _____

Cell_____ Work _____

**Contact Person**

Last Name _____ First Name _____ Relation _____

Address _____ Apt. _____ Zip Code _____

Does the student reside at this address? _____ (Y/N) Phone Numbers: Home _____

Cell_____ Work _____

**Other Emergency Contact _____ Home phone _____**

**Work phone _____ Student's Doctor/Clinic _____ Doctor's phone _____**

**Clinic's phone _____**

**Special medical conditions/allergies/procedures of which the school should be aware: _____**

**_____**

**Medicines taken regularly at home: _____**

**Medicines taken regularly at school: _____**

**Does the student have:**

**Private Insurance _____ (Y/N)**

**Medicaid _____ (Y/N)**

**LACHIP _____ (Y/N)**

**Does the parent/guardian request insurance information? _____ (Y/N)**

**All of the information given on this form is correct.**

**PARENT/GUARDIAN SIGNATURE _____ DATE _____**

**STUDENT HEALTH SERVICES: I understand that Health Care Centers in Schools/School Health Team ("Health Team") will provide school health services in cooperation with <Insert School Name>staff as outlined in the attached summary, and give permission for the Health Team, or any <Insert School Name>employee or any other staff under the guidance of the Health Team, to provide the described services to the student as he/she may require while present in school. I understand that, if the student has a serious injury or illness, I will be contacted and the physician/clinic shown on this form and/or Emergency Medical Services (EMS) may be contacted if necessary. I understand and agree that neither Health Care Centers in Schools nor <Insert School Name>nor their staff will be responsible for any cost involved if the student needs emergency medical care. I understand and agree that, in order to provide a coordinated system of care, the health team or <Insert School Name>employee may exchange health care information about the student with the student's physician or other health care providers, upon approval by me. I understand and agree that the Health Team may share the student's health care information with <Insert School Name>personnel, in accordance with protocol, in order to provide appropriate attention to the Student's health needs. I further understand that my signature approves an <Insert School Name>employee to give permission for my child to be treated in the event that I am not able to be reached for approval.**

**PARENT/GUARDIAN SIGNATURE _____ DATE _____**