11.20

HEALTH *FIRST* BLUEGRASS

Student Health Information

(Please complete one form per student)

496 Southland Drive
Lexington, Kentucky 40503
(859) 288-2425
(859) 288-7510 FAX

SCHOOL: _____ SCHOOL YEAR: _____

Last Name :_____ First Name : _____ MI : ____

(Please give student's complete legal name.)

Student's Social Security #_____ Birth Date: _____

Race: _____ ☐ Male ☐ Female Home Room Teacher: _____

Street Address_____ City_____ Zip _____

Mother _____ Hm Ph _____ Wk Ph _____ Cell Ph _____

Father _____ Hm Ph_____ Wk Ph _____ Cell Ph _____

Legal Guardian _____ Hm Ph_____ Wk Ph _____ Cell Ph_____

Emergency Contact Person **OTHER** than Guardian or Parent _____

Relationship: _____ Hm Ph _____ Wk Ph _____ Cell Ph _____

STUDENT'S Medical Insurance

Does your student have a KY Medicaid or K-CHIP Card? Yes ◯ No ◯ Number _____

Does your student have other medical insurance? Yes ◯ No ◯ Name of Company_____

STUDENT'S Medical History

1) Significant Medical History: _____

2) Medication Allergies: _____ Food Allergies: _____

3) Other Allergies: _____

4) Medications taken Daily: _____

5) * Prescription Medication to be given at School: _____

Student's Health Care Provider: _____ Phone: _____

* *Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

Does your student have any of the following life-threatening conditions that may require <u>EMERGENCY</u> treatment or medications to be given at school?

☐ **DIABETES (Glucagon)**	☐ **ASTHMA (Rescue Inhaler)**	☐ **SEIZURES (Diastat)**	☐ **LIFE-THREATENING ALLERGY (Epi-Pen)**	☐ **OTHER:** _____

CONSENT FOR HEALTH SERVICES / ASSIGNMENT OF BENEFITS

All students will receive basic First Aid and emergency care. By signing this form, I consent to School Health services given to my student by Nurses or agents of HFBG while at school. I authorize HFBG to release medical information about my student to his/her Primary Care Provider. I also understand that the information obtained from the School Physical, including Immunization information, will be released to my student's school. If I or my student has Medicaid or KCHIP, I authorize HFBG to release this information to Medicaid/KCHIP so that Medicaid/KCHIP can be billed for services provided by the School Nurse, at no cost to me. I give further consent to HFBG to enter my student's immunization data into the KY immunization registry.

I also understand that by signing this consent, I acknowledge that I have access to a copy of the HealthFirst Bluegrass Privacy Notice located at www.healthfirstlex.com or I may request a copy by calling my school-based clinic site or 859-288-2425.

X_____ _____/_____/_____

(Signature of Parent / Legal Guardian / Emancipated Student) *(Date signed)*

THIS SECTION FOR SCHOOL USE ONLY

☐ **Care Plan(s) Sent** **Date:** _____ **Date:** _____ **Date:** _____	☐ **Care Plan(s) Returned** **Date:** _____ **Date:** _____

Please Return Completed Form To School Nurse