School Year: 2023-2024

The Preuss School UC San Diego
Health Information Exchange Consent

Child's full name:__________________________________ Birthdate (MM/DD/YYYY): ________________

School: The Preuss School Grade: _______

Home Number:______________ Work Number: ______________ Cell Number: ____________

Physician's Name/ Clinic:__________________________ Telephone #: ______________

____ ☐NO Physician ☐NO Health Plan

Health Insurance Plan:____

(If Medi-Cal, Healthy Families, or another plan, please write the name of the health Plan)

☐ My children **do not have health 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 explain)

Asthma:
Allergies:
Behavior/Emotional Problems (i.e. ADHD): Diabetes:
Heart Problem: Kidney Diseases: Seizure Disorder:
Skin Condition:
Ear Problem/Hearing Defect:
Eye Problem/Glasses:
Operations, Fractures, Head Injury:
Other Health Information:

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:** ____________________

___________________________ ___________________________ __________

Parent/Guardian Signature or Authorized Representative of Minor **Parent/Guardian Name (Print)** **Date**

There are occasions when an over-the-counter (OTC) medication may be given.

Please check if you would like the school nurse or other trained staff, after assessment, to provide the following over-the-counter medications, if indicated as appropriate: Ibuprofen, acetaminophen, antacids or calamine lotion:

☐ YES ☐ NO

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

___________________________ ___________________________ __________________

Parent/Guardian Signature or Authorized Representative of Minor Parent/Guardian Name (Print) Date