Jemez Mountain Public Schools HEALTH AUTHORIZATION FORM

Grade _____ Home Room Teacher_____

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parent's cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	Middle Initial:	Gender: M F	DOB:
NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:				

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian cannot be reached. PLEASE KEEP THESE NUMBERS CURRENT!

Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3
Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: ☐ Lives With ☐ Legal Guardian		Phone #3

Emergency Contact List	Relationship	Phone #1	Phone#2	Phone #3
1.				
2.				
3.				
4.				

Siblings in Other Schools

	Name	School/Daycare	Grade	DOB
1.				
2.				
3.				

SECTION TWO - STUDENT HEALTH HISTORY – Please check appropriate box

☐ **My child has no health conditions including those listed below**

☐ Allergies: ☐ Seasonal	☐ Food (List):	☐ Other Allergy (List):	☐ Has EpiPen prescription
☐ ADD/ADHD	☐ Congenital/Genetic	☐ Ear/Nose/Throat	☐ Pulmonary (Other than Asthma)
☐ Asthma Needs Inhaler at School: Y N	☐ Eye/Vision Wears glasses/contacts: Y N	☐ Diabetes (circle one) Type 1 Type 2	☐ Cardiovascular (List) High Blood Pressure: Y N
☐ Cancer	☐ Dermatologic/Skin	☐ Stomach/GI	☐ Musculoskeletal
Long Term Medications (List):	☐ Eating Disorder	☐ Bladder/GU	☐ Dental/Oral
	☐ Endocrine Other than Diabetes	☐ Hematology/Bleeding Disorders	☐ Psychiatric (List Meds):
☐ Any Other Health Conditions:		☐ Migraines	

SECTION THREE - INSURANCE INFORMATION

Student's Insurance:	Subscribers Name:	ID#

TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

Parent/Guardian Signature: _____ Date: _____

ANNUAL PATIENT REGISTRATION FOR SBHC SERVICES
School Based Health Center SY 2023-2024

STUDENT INFORMATION

Patient Name (last, first, middle)	Date of Birth	Social Security Number	Grade
Patient Mailing Address (city, state, and zip)	Patient Phone - Home		
	Patient Phone - Cell		
Mother's Name Birth Date Mothers Phone Number	Patient Sex ☐Male ☐Female ☐Transgender ☐Black ☐White ☐Native American/Alaska Native Patient Race ☐Hispanic ☐Other		
Father's Name Birth Date Fathers Phone number	Student's Phone number-Cell With whom does child live? (Name and Phone number)		
Emergency Contact Person Name and Relationship to Patient	Emergency Phone - Home Emergency Phone - Cell Emergency Phone - Work		

PRIMARY CARE INFORMATION

Primary Care Provider	Primary Care Provider Phone Number
Primary Care Provider Address	Date of last visit with primary care provider
Comprehensive Well Exam (physical, EPSDT, well child visit, annual check-up) in last 12 months? ☐ Yes ☐ No ☐Not sure	****Annual comprehensive well exams are recommended by the American Academy of Pediatrics to ensure health concerns are identified and treated long before they become chronic. If you have not had a well exam in the last 12 months feel free to call our clinic and schedule 505-455-4026****
Would you like your child to have a well exam in the SBHC this school year? ☐ Yes ☐ No	

Insurance Information

Name of Health Insurance (If no insurance coverage, please enter N/A)	Medicaid Coverage ☐Yes ☐No ☐ Blue Cross/Blue Shield ☐Centennial Care (CC) ☐United CC ☐ Molina CC ☐Presbyterian CC ☐Fee-For-Service
Policy Number	Medicaid Number
Name of Policy Holder Date of Birth of Policy Holder / /	Relationship to Patient

Patient's Name: | **Date of Birth:**

Patient Medical History

Medications:

Hospitalizations:

Surgeries:

List any family health conditions which may be inherited (i.e. high blood pressure, heart disease):

Is patient allergic to or have you had any reactions to the following:	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other antibiotics, aspirin	☐	☐
Barbituates	☐	☐
Sulfa Drugs	☐	☐
Any other Allergies? If yes, please list: _____	☐	☐

Does your child have any of the following?

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Arthritis	☐	☐
Rheumatic Fever	☐	☐	Joint Replacement or Implant	☐	☐
Swollen Ankles	☐	☐	Hepatitis / Jaundice	☐	☐
Fainting/ Seizures	☐	☐	Sexually Transmitted Disease	☐	☐
Asthma	☐	☐	Stomach Troubles / Ulcers	☐	☐
Low Blood Pressure	☐	☐	Chest Pains	☐	☐
Epilepsy / Convulsions	☐	☐	Easily Winded	☐	☐
Leukemia	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Hay Fever / Allergies	☐	☐
Kidney Diseases	☐	☐	Tuberculosis	☐	☐
AIDS or HIV Infection	☐	☐	Radiation Therapy	☐	☐
Thyroid Problem	☐	☐	Glaucoma	☐	☐
Heart Disease	☐	☐	Recent Weight Loss	☐	☐
Cardiac Pacemaker	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Heart Trouble	☐	☐
Angina	☐	☐	Respiratory Problems	☐	☐
Emphysema	☐	☐	Other _____	☐	☐
Frequently Tired	☐	☐	Use Contact lenses?	☐	☐
Anemia	☐	☐			

Consent for Services

I give Permission for SBHC Staff to Administer the following Over the Counter Medecines. **PLEASE INITIAL**

_____TYLENOL_____TUMS_____ALLERGY MEDS_____IBUPROFEN_____MYLANTA_____COUGH DROPS

I give permission for my child, named above, to receive SBHC services and for SBHC staff to access my child's class schedule (for appointment purposes only). I also give permission for the SBHC staff to consult with and provide information and records to other medical/dental care and mental health providers, including school health professionals, and for purposes of program evaluation and quality assurance. I understand that health records are confidential and will not be open to the school or other outside personnel unless the parent/guardian gives written consent, or in the case of treatment for which the minor has given consent, unless the minor gives written consent. I have received a copy of LCDN notice of privacy. I also understand that New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older. I hereby authorize LCDN to bill my insurance. I authorize payment directly to LCDN of all insurance benefits otherwise payable to me for services rendered to myself or my dependents. I authorize LCDN to release any information concerning my dependent's illness and treatment, including conveyance of such information by electronic means, required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Parent/Guardian_____Date_____

Signature of patient if 18 years or older_____Date_____

JEMEZ MOUNTAIN Public Schools

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PARENT PERMISSION AND INSTRUCTIONS FOR OVER-THE-COUNTER MEDICATION AT THE SCHOOL NURSES OFFICE

Student _____ Grade _____

DOB _____

I give permission for my child to take the following medication at school, (students may not carry medication at school), with the supervision of the nurse:

Tylenol Regular (325 mg) Yes No Number of Tablets/ Teaspoons ____

Extra Strength (500 mg) Yes No Number Of Tablets/Teaspoons ____

Age/Weight Appropriate Dose (Elementary) _____

Ibuprofen (Motrin/ Advil) 200 mg Yes No

Age/Weight Appropriate Dose (Elementary) _____

Antihistamines (Benadryl/ Sudafed) Yes No Number of Tablets/ Teaspoons

I will provide a bottle for my own child Yes No

Other Medication _____

(Parent must supply (N/A if not neccissary)

In addition, school nurse may use saline eye drops, cough drops, Tums, antibiotic cream, and hydrocortisone cream

Signature _____ Date _____