DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

2020-21 School Year

Dear Parent or Guardian,

In order to ensure the health and safety of your child and to provide any necessary accommodations to meet your child's health-related needs, we ask that you complete the attached forms:

1. **Annual Health Information Form**
    a. This form will be used to meet your child's health needs at the school.
    b. Please complete all sections of the form and then sign and return it to your child's teacher as soon as possible. Every student must have a new form completed each year.
2. **Information Sharing Agreement**
    a. This form will allow us to work with each of the different health service providers in the district, in order to coordinate care and keep you child healthy and safe at school.
    b. Please review this form and then sign and return it to your child's teacher as soon as possible.
3. **Emergency Contact and Medical Authorization Form**
    a. This form requests emergency contact information and gives permission for a physician, licensed nurse, or other school employee designated by school administration, to administer medical treatment to your child in an emergency.
    b. Please complete all sections of this form and then sign and return it to your child's teacher as soon as possible.
4. **Authorization for Release of information**
    a. This form will allow your child's health care provider to share health related information with the school.
    b. If your child meets the criteria at the top of the form, please complete all sections and return to your child's teacher as soon as possible.
5. **Permission Form for Prescribed Medication - Not included in packet; separate form available on Office of School Health and Wellness website**
    a. This form is required in order for your child to use or keep medications at school.
    b. This form must be completed and signed by both the parent and the child's health care provider and then returned to the school.
    c. If your child does not require medications at school, then you do not need to complete this form.

Thank you for your assistance and please don't hesitate to reach to your school with any questions or concerns.

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ANNUAL HEALTH INFORMATION
2020 - 2021

Dear Parent/Guardian: The information on this form will be used to meet your child's health needs at the school. Please complete all sections of the form and then sign and return it to your child's teacher as soon as possible. Every student must have a new form completed each year.

School Name:	Grade:	Is your child new to the district? ☐ Yes ☐ No	
Student's Last Name:	First Name:	Middle Name:	Suffix (Jr., III, etc.)
Date of Birth: / /			
Parent/Guardian Name:		Relationship to student:	
Home or Cell Phone: ( )		Work Phone: ( )	
Health Care Provider Name:		Health Care Provider Phone: ( )	
Date of last physical: / / ☐ Unsure		Date of last dental exam: / / ☐ Unsure	

What type of insurance does your child have?

- ☐ Medicaid
- ☐ Private
- ☐ Unsure
- ☐ My child does not currently have insurance

If your child has Medicaid, please mark the plan name:

- ☐ Aetna
- ☐ Blue Cross Complete
- ☐ HAP Midwest
- ☐ McLaren
- ☐ Meridian
- ☐ Molina
- ☐ Total Health Care
- ☐ United
- ☐ Other

Does your child have any of the following health conditions?

HEALTH CONDITION	YES	NO	HEALTH CONDITION	YES	NO
Severe allergies (food, insects, drugs, latex) If yes, please state what your child is allergic to (certain foods, insects, latex, etc) If yes, please check the reaction that occurs: ☐ Hives ☐ Swelling ☐ Trouble breathing ☐ Other			Depression		
			Diabetes		
			Head Injury or Concussions		
			Hearing Problems		
			Heart Problems		
			Lead Poisoning		
			Pregnant		
			Seizures		
Allergies (seasonal)			Sickle Cell Disease		
Anxiety			Speech Problems		
Asthma or breathing problems			Vision Problems		
Attention Deficit Hyperactivity Disorder			Wears Glasses		
Behavioral Problems			Other Health Conditions, please list:		
Bladder or Bowel Problems					
Dental Problems					

MEDICATIONS AND/OR SPECIAL PROCEDURES*

Does your child require any daily medications to be taken at school?	☐ Yes*	☐ No
Does your child require any emergency medications be kept at school?	☐ Yes*	☐ No
Does your child require any special procedures to be done at school? (g-tube feeding, catheterization, etc.)	☐ Yes*	☐ No

***If you answered yes to any of the above questions under Medications and Special Procedures, please have your child's health care provider complete the attached medication/procedure authorization form. The form must be signed by both the health care provider and the parent, and must also be renewed every year.**

FAMILY NEEDS

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ☐ Yes ☐ No

ACKNOWLEDGMENTS & SIGNATURE

I certify that this information is correct to the best of my knowledge and understand that it is my responsibility to inform the school if any of this information changes. I also understand that this information may be shared with need-to-know staff at my child's school in order to keep my child safe and protected while at school.

Parent or Guardian Signature	Print Name	Date

TO BE COMPLETED BY OFFICE STAFF

	DATE	STAFF PERSON
Form Received		
Information entered into Student Information System		

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CONSENT TO RELEASE HEALTH INFORMATION

STUDENT INFORMATION

Student's Last Name:	First Name:	Middle Name:	Date of Birth: / /
Parent/Guardian First and Last Name:		Home or Cell Number: ( )	

CONSENT FOR RELEASE OF INFORMATION

By signing this Consent to Release Information form, I consent to the following:

- I authorize my child's school to disclose the following student information to the individuals/groups listed below: child's family and emergency contact information, attendance and disciplinary records, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education records, section 504 accommodation plan and any information related to medical conditions, such as asthma, diabetes or seizures.
  - My child's Health Care Provider(s)
  - My child's Health Insurance Plan
  - Michigan Dept. of Health and Human Services and Detroit Health Dept. (immunization records only)
  - School-based health service providers – see below
- I understand that sharing this information will allow DPSCD to work with each of these individuals/groups to coordinate care, provide outreach services if necessary, and keep my child healthy and safe at school.
- I understand that I am entitled to receive a copy of any disclosed records. (If you wish to receive a copy please provide an email or street address to which where the records should be sent.)
- I understand that these individuals may further use records provided by DPSCD for contacting me and/or verifying information for student health related purposes.
- I understand that my authorization to allow sharing the above information is voluntary and that it expires when my child leaves the school district, or graduates. **I understand that I may revoke this authorization at any time by submitting a note or letter in writing to the school administration office.**

School-based health service providers may include any of the following:

- School Based Health Centers (SBHC): ability to diagnose and treat many common conditions such as sore throats, headaches, and ear infections, and also manage chronic health conditions. The SBHC may also provide behavioral health services.
- Dental Services: may include oral health education, screenings, fluoride varnish application, preventative care and cleaning, restorative/corrective care.
- Vision Services: may include screening, examination, treatment and/or corrections such as eyeglasses.
- Immunization Services
- Behavioral Health Services

In order for your child to receive these services, from these providers, you will need to complete a separate enrollment form with each of the providers.

Parent/Guardian Name:	Relationship to Child:	Date: / /

PERMISSION FOR COLLABORATION FOR YOUR CHILD'S HEALTH

Health Care Providers, Health Plans and Health Departments

Family Educational Rights and Privacy Act (FERPA)

What is FERPA?

The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. Generally, schools must have written permission from the parent, or student if over 18, in order to release any information from a student's education record.

Permission for what?

Detroit Public Schools Community District is requesting your consent because we may need to share information contained in our student records with your child's Health Care Provider, Health Insurance Plan, a School-Based Health Service Provider, or as required by law, including to the Michigan and Detroit Departments of Health. Health Care Providers are the physician(s) or nurse practitioner(s) who take care of your child, as noted in the district's records. A Health Plan is an organization that administers your child's health care benefits, such as Medicaid or a health insurance company.

Why is this important?

This consent form allows the district, when requested or necessary by law, and/or to assist with coordination of health care, including benefits, by sharing health information from the student's education record. Without your consent, the district is limited in how it can collaborate with your child's Health Care Provider, Health Insurance Plan, or a School-Based Health Service Provider to help you or your child.

*What this form **does not** do.*

- This form only authorizes the district to disclose information for limited purposes, with your consent. Each Health Care Provider, Health Insurance Plan, or a School-Based Health Service Provider may have its own way of getting permission from you for them to share information with the district.
- Your signature **does not** authorize the district to obtain medical treatment for your child on your behalf.

Please help us link you and your child to health services by signing and returning the previous page.

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DISTRICT EMERGENCY CONTACT AND MEDICAL AUTHORIZATION FORM

SCHOOL: _____ **SCHOOL YEAR:** _____

STUDENT INFORMATION

First Name:	Last Name:	Date of Birth: / /
Grade:	Homeroom Teacher:	Homeroom Classroom Number:
Home Address Street:	City:	ZIP:
Student Cell Phone Number: ( )	Student Email:	

Who does the student live with? Select all that apply:

☐ Mother ☐ Father ☐ Guardian ☐ Grandparent ☐ Other Relative ☐ Other _____

EMERGENCY CONTACTS INFORMATION

PRIMARY CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other _____

SECONDARY CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other _____

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other _____

EMERGENCY CONTACTS INFORMATION - CONTINUED

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Step Parent ☐ Legal Guardian ☐ Other _____

SIBLINGS IN STUDENT'S HOME

Please list all siblings in student's home (include non-school age children)

Name:	Grade:	Date of Birth: / /
Name:	Grade:	Date of Birth: / /
Name:	Grade:	Date of Birth: / /
Name:	Grade:	Date of Birth: / /

CONSENT TO CONTACT MEDICAL CARE PROVIDERS / HOSPITALS

PART 1 - TO GRANT CONSENT

Only Part 1 or Part 2 below must be completed and signed.

Doctor's Name:	Phone: ( )	Address:
Dentist's Name:	Phone: ( )	Address:
Medical Specialist (optional):	Phone: ( )	Address:
Local Hospital:	Emergency Room Phone: ( )	Address:

Emergency Medical Authorization I hereby give permission for a physician, licensed nurse, or other school employee designated by school administration, to administer medical treatment to my child in an emergency, including as a result of athletic participation, that threatens the life or health of my child. I understand that school staff and medical personnel will be acting in good faith, in accordance with applicable law and in the best interest of my child. DPSCD staff will adhere to applicable policies as well. By providing this consent, to the extent permitted by law, I voluntarily with full knowledge of its significance, release and hold harmless DPSCD, the Board of Education and its staff, contractors, agents, and volunteers from liability resulting directly or indirectly from the medical treatment provided. I further authorize a physician, licensed nurse or other school employee designated by school administration to cause my child to be transported to the nearest hospital for treatment in an emergency. I hereby assume responsibility for the costs of any medical treatment and transportation provided to my child which may include indemnification of DPSCD for such costs.

Signature of Parent/Guardian:_____ Date_____

Note: The above information will be shared with appropriate staff as necessary. This includes, but is not limited to, administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches, and substitute employees. Please, notify the school nurse of any concerns.

PART 2 - REFUSAL TO CONSENT

Do not complete Part 2 if you completed Part1.

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school/district authorities to take the following action:

Signature of Parent/Guardian:_____ Date_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please ONLY complete if your child meets one of the following:

- ☐ Receives special education services at school
- ☐ Requires daily or emergency medications at school
- ☐ Requires special procedures to be performed at school (e.g.-tube feeding, catheterization, etc)
- ☐ Has a chronic health condition, such as asthma, diabetes, seizures, severe allergic reaction, etc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request and authorize the following to release to the Detroit Public Schools Community District, Office of Student Information Services, medical information regarding my child:

Physician/Medical Facility: _____

Phone Number: _____

Child Name: _____ Date of birth: / /

I understand that this authorization is voluntary and will expire when my child leaves the district or is terminated by me in writing.

Parent/Guardian Name: _____

Signature: _____

Relationship to Child: _____

Address: _____

Telephone Number: _____

Date: / /