Bruce-Guadalupe Community School | United Community Center / Centro de la Comunidad Unida | United Community Center Acosta Middle School

Student Health Information & Consent to Treat

Student Name: (Last, First)			
Date of Birth:		**Grade:**	
1. Is your child a **currently registered patient** with Sixteenth Street Community Health Centers?		☐ **Yes**	☐ **No**
2. Do you give consent for your child to receive **general first aid care** & treatment at school by our school staff?		☐ **Yes**	☐ **No**

3. Health Information

Check ☑ if your student has any of the following:	*For your child's safety at school, briefly provide information, special accommodations and/or restrictions for the condition:*
☐ No Health Conditions ☐ Asthma: ☐ ADD, ADHD: ☐ Blood Disorder (ex. Anemia, Hemophilia, etc.): ☐ Diabetes: *Type 1 or Type 2* ***(circle one)*** ☐ Heart Condition: ☐ Seizure/Epilepsy: *Date of last seizure:* _____ ☐ Hearing Problems: ☐ Vision Problems: (ex. glasses/contacts) ☐ Other Health Condition: ☐ Take prescription medication at home: ☐ Prescription medication needed at school*:	***Medication Authorization form MUST be on file**

4. Allergy Information

Check ☑ if your student has any of the following:	*Explain what your student is allergic to and what occurs when exposed to the allergen:*
☐ Food Allergy: _____ ☐ Medication Allergy: _____ ☐ Insect (bite or sting) Allergy: _____ ☐ Other Allergy: _____	

Is the allergy severe or life-threatening? ⬜ NO ⬜ YES

If YES: Medication Authorization Form MUST be on file (available online or in school office) AND an Epi-Pen provided to keep at school

5. By signing, I verify that all the information provided above is correct, to the best of my knowledge.

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**

All medical information provided to the Student Health Center is protected by federal privacy laws and will be kept confidential. However, if necessary, relevant information may be disclosed to school personnel and other health care professionals if such information is needed to respond to health and safety concerns of the student. All shared information will continue to be confidential as per Wis. State. Sec 146.82 (1). This information may also be shared with emergency medical staff in the event of an emergency requiring transport to a medical facility.

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Student Health Information & Consent to Treat

Nombre del alumno: *(Apellido, Nombre)*			
Fecha de nacimiento:		**Grade:**	
1. ¿Es su hijo un **paciente registrado actualmente** en Sixteenth Street Community Health Centers?		☐ **Sí**	☐ **No**
2. ¿Da su consentimiento para que su hijo reciba **atención general de primeros auxilios** y tratamiento en la escuela por parte de nuestro personal escolar?		☐ **Sí**	☐ **No**

3. Información de Salud

Marque ☑ si su estudiante tiene algo de lo siguiente:	*Para la seguridad de su estudiante en la escuela, proporcione información breve, adaptaciones especiales y/o restricciones para la condición:*
☐ Sin condiciones de salud ☐ Asma: ☐ ADD, ADHD: ☐ Trastorno sanguineo (ej. Anemia, Hemofilia, etc.): ☐ Diabetes: *Tipo 1 or Tipo 2* ***(circule uno)*** ☐ Condición cardiaca: ☐ Epilepsia/Convulsiones: *Fecha del último episodio:* _____ ☐ Problemas para escuchar: ☐ Problemas de visión: (ej. lentes/contactos) ☐ Otro problema de salud: ☐ Toma medicamentos recetados en casa: ☐ Medicamentos recetados necesarios en la escuela*:	***El formulario de autorización de medicamentos DEBE estar en el archivo; formularios en línea o en la oficina de la escuela**

4. Información sobre Alergias

Marque ☑ si su estudiante tiene algo de lo siguiente:	*Para la seguridad de su estudiante en la escuela, explique brevemente a qué es alérgico su estudiante y qué ocurre cuando es expuesto/a:*
☐ Alergia a la comida: _____ ☐ Alergia a medicamentos: _____ ☐ Insecto (mordedura o picadura) Allergy: _____ ☐ Otra alergia: _____	

¿La alergia es grave o pone en peligro la vida? ⬜ **NO** ⬜ **SÍ**

Si indico SÍ: El formulario de autorización de medicamentos DEBE estar archivado (disponible en línea o en la oficina de la escuela) Y una Epi-Pen para mantener en la escuela

5. Al firmar, verifico que toda la información proporcionada anteriormente es correcta, según mi leal saber y entender.

_____ _____ _____

Nombre del Padre/Guardián (Letra en Molde) **Firma** **Fecha**

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