

CLAY COUNTY SCHOOLS  
Student's Profile Sheet

Child's Name \_\_\_\_\_ Bus No. \_\_\_\_\_ WVEIS No. \_\_\_\_\_  
Last, First Middle

Grade \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Child's Mailing Address \_\_\_\_\_  
Street or PO Box, City, State Zip

Child's Physical Address \_\_\_\_\_

Telephone (Parent/Guardian) \_\_\_\_\_ Work Telephone Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Please circle. Living Deceased Divorced Please circle. Living Deceased Divorced

Step-Father's Name \_\_\_\_\_ Legal Guardian's Name(s) \_\_\_\_\_

Step-Mother's Name \_\_\_\_\_ Foster Parent Name(s) \_\_\_\_\_

Name of person with whom student lives \_\_\_\_\_

Does your child require Special Education Services? YES \_\_\_\_\_ NO \_\_\_\_\_

HEALTH HISTORY

Does your child have any of the following conditions?

- |                          |                           |                           |                               |
|--------------------------|---------------------------|---------------------------|-------------------------------|
| _____ Allergies          | _____ Cystic Fibrosis     | _____ Hyperactive/ADHD    | _____ Seizure/Epilepsy        |
| _____ Anorexia/Bulimia   | _____ Depression          | _____ Intestinal problems | _____ Spina Bifida            |
| _____ Arthritis          | _____ Diabetes            | _____ Leukemia            | _____ Sports injury/Fractures |
| _____ Asthma             | _____ Ear infections      | _____ Multiple Sclerosis  | _____ Thyroid disease         |
| _____ Bladder infections | _____ Emotional problems  | _____ Pneumonia           | _____ Tourette's syndrome     |
| _____ Bleeding disorder  | _____ Headache            | _____ Prosthesis          | _____ Tuberculosis            |
| _____ Cancer             | _____ Heart problems      | _____ Scoliosis           | _____ Ulcers/GERD             |
| _____ Cerebral Palsy     | _____ Hearing problems    | _____ Severe Acne         | _____ Vision problems         |
| _____ Chicken Pox        | _____ High blood pressure | _____ Sinus problems      | _____ Weight problems         |

Describe any other health problems. \_\_\_\_\_

List any surgeries. \_\_\_\_\_

List any activity restrictions. \_\_\_\_\_

List daily medications. \_\_\_\_\_

Will student need to take medication at school? YES \_\_\_\_\_ NO \_\_\_\_\_

Will student need special health care procedures at school? YES \_\_\_\_\_ NO \_\_\_\_\_

Describe procedure. \_\_\_\_\_

DOES YOUR CHILD HAVE SEVERE REACTIONS TO BEE STINGS REQUIRING AN INJECTION OF MEDICATION?

YES \_\_\_\_\_ NO \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS, EMERGENCY MEDICAL SERVICES WILL BE CALLED.  
THE STUDENT WILL THEN BE TRANSPORTED TO THE NEAREST HOSPITAL AT THE PARENT'S EXPENSE.

This information, along with my child's immunization record, may be shared with school personnel, wellness center personnel, and other health professionals pertinent to my child's health. My child's immunization record can be shared with the West Virginia Statewide Immunization Information System.

SIGNATURE (PARENT/GUARDIAN) \_\_\_\_\_ DATE \_\_\_\_\_

# FERPA/HIPAA CONSENT

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN DENTAL/MEDICAL PROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

### USE AND DISCLOSURE INFORMATION:

Patient/Student Name: \_\_\_\_\_  
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) \_\_\_\_\_ (2) \_\_\_\_\_

to provide health information from the above-named child's medical record to and from:

<u>Clay County Schools</u>	<u>PO Box 120 Clay, West Virginia 25043</u>
School District to Which Disclosure is Made	Address / City and State / Zip Code
<u>Alicia Johnson, Jennifer Moore, or Lindsay Schoolcraft</u>	<u>304 587 4266</u>
Contact Person at School District	Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following:

All minimum necessary health information; or  Disease-specific information as described:

### DURATION:

This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for one year from the date of signature, if no date entered.

### RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

### YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

### RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

### APPROVAL:

\_\_\_\_\_  
Printed Name Signature Date

\_\_\_\_\_  
Relationship to Patient/Student Area Code and Telephone Number