MEDICAL INFORMATION

Please PRINT Neatly

School Name: Stoughton High School

1. Student's Name: _____ 2. Age: _____

3. Address: _____ 4. Date of Birth: _____

5. Student's Social Security No. _____ 6. Phone No. _____

7. Parent or Guardian Name: _____

8. Emergency Contact's Name 1: _____ Phone _____ Cell_____

Name 2: _____ Phone _____ Cell_____

Name 3: _____ Phone _____ Cell_____

9. Business Address: _____ 10. Business Phone: _____

11. Does student have insurance through parent employer ? _____

12. If yes to No. 11, Name of Insurance Co. _____

13. Policy No. for No. 10: _____

14. Health History: (check)

____ Diabetes
____ Orthopedic Problems
____ Asthma
____ Epilepsy
Cardiac Problems

15. Allergies: (check)

Medications ___ specific _____
Food ___ specific _____
Insect Stings ___ specific _____

TREATMENT

16. Do we have your permission to administer to your child? (check)
_____ Ibuprofen _____ Tylenol

17. Has your child had a tetanus shot current to within 6 years?
_____ Yes _____ No

18. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, allergies (other than drugs) or other physical condition.

19. Are there any **medications** that your child will be required to take during the trip? Please explain: Students needing to take prescription medicine must bring a parent's note indicating permission and method of ingestion. Medication (prescription and generic) must be kept in original bottles/containers.

PARENT'S AUTHORIZATION: This health history is correct to the best of my knowledge and the student herein described has permission to engage in all activities, unless noted by me. I give permission to the physician or hospital selected by a medical representative of my son or daughter's school to hospitalize, secure proper treatment for and to order medications, injections, anesthesia or surgery for my child as named above.

_____ _____
Parent or Guardian Signature Date

PLEASE READ AND SIGN THE HIPAA PRIVACY FORM ON BACK

Any information given on this form will be held in strict confidence

Stoughton Public Schools
SCHOOL TRIP
Medical Form Addendum re: Confidentiality and HIPAA Privacy

The Massachusetts Department of Public Health Privacy Officer and the Office of the General Counsel have concluded, that physicians and other licensed providers whose business activities (such as that of a school nurse) fall under the HIPAA (Health Insurance Portability and Accountability Act), (45CFR I64.512 b) regulations are considered that of a hybrid entity. This means that the Department of Public Health, as a whole, is considered a covered entity whose business activities include both covered and non-covered functions.

Determining that the Department is a hybrid entity also means that the release of PHI (Patient Health Information) from a covered component to a non-covered component is considered a disclosure under HIPAA and not permitted unless there is an individual authorization or a specific exemption aloowing the disclosure. The Privacy Rule requires the Department, and those working under the Department, to assure that PHI is not improperly disclosed.

Given the above noted, I give authorization for the School Nurse to share information with the licensed Registered Nurse / Parental volunteer who will be attending the upcoming trip that my child _____ will be attending.

The licensed registered Nurses who will be attending the trip will sign a confidentiality waiver, and any information shared with them for the purposes of providing health care to your child will be kept in strict confidence in provision with the HIPPA laws.

Parent / Guardian Consent

_____ Date _____

parent / guardian signature