SHERIDAN COMMUNITY SCHOOLS

BLACKHAWK CARE (BHC) PARENT CONSENT

Student's Name: _____ Male _____ Female _____ Ethnicity: _____
(A separate registration for each child, please.)

Birth Date _____/_____/_____ Grade Level: _____ Homeroom Teacher (if known): _____

Please check Student's Program enrollment:

☐ AM only ☐ AM/PM

☐ PM only ☐ Occasional Care

PARENTS / GUARDIANS:

Legal Custodian of Student: _____ Relationship: _____

MOTHER'S Name: _____ Home Phone: _____
(This will be first emergency contact unless otherwise noted.)

Address: _____ City: _____ Zip: _____ Page / Cell: _____

Workplace / Hours: _____ Work Phone: _____

E-mail Address: _____

FATHER'S Name: _____ Home Phone: _____

Address: _____ City: _____ Zip: _____ Page / Cell: _____

Workplace / Hours: _____ Work Phone: _____

E-mail Address: _____

Name of person responsible for BHC fees, if different from above: _____

Home Phone: _____ Mailing Address: _____

EMERGENCY NUMBERS:

Give two local adults who could be reached during BHC hours if a Parent / Guardian is not available.

Name: _____ Relationship: _____ Phone: _____
(Give all applicable numbers)

Name: _____ Relationship: _____ Phone: _____
(Give all applicable numbers)

PICK UP AUTHORIZATION:

Person(s) authorized to pick up your child, in addition to the above names listed. Any changes must be in writing.

Name: _____ Relationship: _____ Phone: _____
(Give all applicable numbers)

Name: _____ Relationship: _____ Phone: _____
(Give all applicable numbers)

RELEASE OF SCHOOL INFORMATION:

I give my permission for BHC staff to access and view School Registration Information and Health Information maintained in the School Front Office and in the Nurse's Clinic.

_____ _____
Parent / Guardian Signature Date

HEALTH RECORDS: (This would be taken to emergency facility if needed.)

Student's Physician: _____ Physician's Phone: _____

Date of most recent physical: _____ Age of student at time of physical: _____

Date of last tetanus shot: _____ Blood type (if known): _____

Local Hospital Preference: _____

Student's Dentist: _____ Dentist's Phone: _____

Information you would want to share in an Emergency Room if you were not present:

_____

_____

_____

_____

_____

HEALTH CONSIDERATIONS:

Allergies: Yes / No If yes, please outline cautions for our staff: _____

_____

Diagnosed Health Conditions: Yes / No If yes, please outline cautions for our staff: _____

_____

Special routines / modifications prescribed by a doctor: Yes / No If yes, please outline cautions for our staff:

_____

_____

PARENT AGREEMENT:

Please read and initial each line below:

_____ I have received and read the BHC Program Design booklet.

_____ I will adhere to procedures and guidelines found in the BHC Program Design booklet.

_____ I understand School Handbook rules apply at BHC.

_____ I will be financially responsible for any fees, medical care, and transportation costs incurred on my child's behalf as outlined in the BHC Program Design handout.

_____ I will pay all court costs, attorney fees, and collection agency fees associated with the collection of delinquent fees.

_____ I will pay fees in accordance to the Fee Schedule and BHC Pay Date Schedule.

_____ I understand the person responsible for the BHC fees can authorize to make one switch in the child's BHC plan during the school year by contacting the superintendent's office at 758-4172. A switch during the school year from either the Access or Basic Plan to School Year Plan to the Occasional Care Plan will include a $35 Occasional Care registration fee charge due at the time of the requested switch.

_____ I will be responsible for medical expenses incurred in the treatment of my child in emergency situations.

_____ I verify that all immunizations are current and are on file with the school nurse.

_____ I have provided all information that will help BHC staff best serve my child(ren).

_____ _____

Parent / Guardian Signature Date