LONG COUNTY SCHOOL HEALTH SERVICES
STUDENT HEALTH INFORMATION
School Year 2018-2019

This information will be kept confidential.
Please complete & sign these forms (Return to the School Nurse)

Student Name:_____DOB:_____ Sex: Male____ Female____
Other Allergies: _____ Grade:_____

PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

I hereby give my consent for my above named child to participate in the School Health Services Program which may include vision, hearing, height, weight, body mass index, nutrition, dental, scoliosis screenings, health/nursing appraisals & assessments. I also give my consent for this information to be shared and/or faxed to my child's doctor/dentist.

In cases of minor accidents or illness, I hereby give my consent for my child to receive routine first aid administered by school personnel. I also give permission for the use of the following over the counter and emergency preparations when needed in the event of minor skin irritation/injury, for minor pain, discomfort, fever, or life-threatening emergency.

Over the counter medications will only be used according to the label directions for the listed purpose and age/size of the student unless an individual physician order is provided. No over the counter medications will be used more than 5 consecutive or 30 cumulative school days per semester without a doctor's order. If an over the counter medication is required by a student more than **5 times, the parent will be required to furnish that medication for future need**. **Over the counter medications will only be provided at the discretion of the school nurse and/or designated staff person, or a physician.** This standing protocol medication procedure is established for the purpose of aiding student attendance, minimizing student discomfort so that they may be more attentive in class, to assist parents by not having to leave their jobs to come to the school each time a student has a minor discomfort or injury and to sustain life in the event of a life-threatening emergency.

STRIKE THROUGH & INITIAL ANY OF THE FOLLOWING MEDICATIONS THAT YOU DO NOT WANT TO BE USED FOR YOUR CHILD

Generic Preparations may be substituted for these listed over the counter products.
The Long County Schools will not be required to furnish medications but will have these on hand as funds are available.

	Tylenol		Vic's vapor rub		Saline **eye drops**		Benadryl liquid/capsules
	Motrin		Chloraseptic throat spray		Visine/Visine allergy eye drops		Albuterol inhaler emergency
	Maalox		1% Hydrocortisone cream		Contact lens cleaning/rewetting drops		Epi pen for anaphylactic reaction
	Tums		Antifungal cream (for suspected ringworm)		Sting Kill		
	Zyrtec		Neosporin cream/ointment		Oragel/Ambesol		
	Claritin		Cough syrup with suppressant (dextromethorphan) and/or expectorant (guaifenesin)		Cough drops		

Date: _____ Parent/Guardian Signature: _____

In case of an accident or illness where my child is unable to remain at school, I request that one of the following be contacted to care for my child in the event that a parent/guardian can't be reached.

Name, Relationship, Cell phone, home phone, work phone

1._____

2._____

3._____

In the event of a major accident or serious illness, I understand the school will make every effort to contact me. School Health personnel have my permission to contact my child's listed physician(s) for further medical information and for instruction if I am unavailable to be reached in the event of an emergency. I, the parent/legal guardian, authorize the transport and treatment by Emergency Medical Services and the hospital emergency staff for my above listed child. Fees for transport and medical services will be the responsibility of the parent/guardian signed below.

****In the event a previously undiagnosed life threatening allergic reaction occurs, the school has my permission to administer the life saving medication, epinephrine. Designated school staff are trained to assess, call 911, and administer epinephrine. When epinephrine is administered the student will be transported to the ER for further evaluation and treatment.**

Date_____Parent/Guardian Signature _____

OR

I **DO NOT** want my child to receive school health services. I agree to be **immediately available** to provide care for my child at school at **ALL times**.

Date_____Parent/Guardian Signature _____

If you have an email address, this is the quickest way to contact you if your child is seen in the clinic for anything other than emergencies.

Parent/Guardian Name #1 _____ Home Phone _____

Email address _____ Cell Phone _____

Place of employment _____ Work Phone _____

Parent/Guardian Name #2 _____ Home Phone _____

Email address _____ Cell Phone _____

Place of employment _____ Work Phone _____

Student Medical Insurance:

_____Private; Name of private insurance _____ _____Peach Care_____Medicaid ____None

Health History: Does your child now have or has he/she ever had:

D **YES** D **NO** D **YES** D **NO**	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication o At school o At Home
D **YES** D **NO**	**Allergies:** o Hives/rash o Epi-pen o **Food** _____ o **Insects**_____ o Breathing difficulty o **Environmental** _____ o **Medications** o Other:
D YES D **NO**	**Asthma** o Uses an inhaler/nebulizer at school o Uses an inhaler/nebulizer at home
D YES D **NO**	**Blood/Bleeding Problems: o Hemophilia, o Von Willebrands, o Other** ***Please explain:***
D YES D **NO**	**Frequent Nose Bleeds:** *Please explain*
D **YES** D **NO**	**Cancer/Leukemia:** *Please explain*
D **YES** o **NO**	**Cerebral Palsy:** *Please explain*
D YES D **NO**	**Cystic Fibrosis:** *Please explain*
D **YES** D **NO**	**Dental Problems:** *Please explain:*
D **YES** D **NO**	**Diabetes** o **Type 1 Diabetes** o Monitors Blood Sugars at school o Requires Insulin at school o Insulin pump o Glucagon order o **Type 2 Diabetes** o Managed with diet o Oral medication
D YES D **NO**	**Emotional/Behavioral/Psychological:** *Please explain:*
D **YES** D **NO**	**Gastrointestinal/Stomach Problems:** o *G-tube* *Please explain:*
D YES D **NO**	**Headaches:** *Please explain:*
D **YES** D **NO**	**Hearing Problems:** o Right Ear o Left Ear o Both ears o Hearing loss o Hearing aid o Tubes o Cochlear Implant
D YES D **NO**	**Heart Condition:** o **Activity restrictions** o **Medications taken at home:** *Please explain:*
D **YES** D **NO**	**Hypertension (High Blood Pressure):** *Please explain:*
D **YES** D **NO**	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*
D **YES** D **NO**	**Kidney/ Bladder/ Urinary Problems:** o *Catheter* *Please explain::*
D **YES** D **NO**	**Scoliosis:** o No Treatment o Wears Brace o Surgery
D **YES** D **NO**	**Seizures/Convulsions:** Type of seizure: _____ *Medications:* o Diastat o Klonopin o Versed o Meds taken at home o Meds taken at school o Vagal Nerve Stimulator *Please explain:*
D YES D **NO**	**Sickle Cell:** o Anemia D Trait
D **YES** D **NO**	**Shunt:** o VP shunt *Please explain:*
D **YES** D **NO**	**Spina Bifida:**
D YES D **NO**	**Vision Problems:** o Wears glasses o Wears contacts o Other
D YES D NO	**Mono in the past year**
D YES D NO	**Other Medical Conditions:** Please include any medications taken at home only. o Tracheostomy o Walker o Wheel chair o Oxygen supplementation o Other: Please explain: