

**LONG COUNTY SCHOOL HEALTH SERVICES  
STUDENT HEALTH INFORMATION  
School Year 2019-2020**

**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 <b>eye drops</b>	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.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**\*\*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:**

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