SITE #:_____ 2018-2019 CONSENT FOR SCHOOL HEALTH SERVICES

*****PLEASE FILL IN *ALL* INFORMATION*****

HOMEROOM TEACHER:_____GRADE:_____ LANGUAGE(S) SPOKEN AT HOME_____

CHILD'S LEGAL NAME_____ BIRTHDATE:_____ RACE:_____ ☐MALE ☐FEMALE

**CHILD'S** SOCIAL SECURITY NUMBER:_____ *(USED FOR BRDHD BILLING ONLY )*

KY MEDICAID ID NUMBER:_____ IS YOUR CHILD EXPOSED TO TOBACCO? ☐YES ☐NO

ADDRESS:_____CITY/ STATE/ ZIP _____

CHILD'S TRANSPORTATION: BUS RIDER CAR RIDER WALKER ATTENDS AFTER SCHOOL PROGRAM AT SCHOOL

GUARDIAN NAME(S):_____

HOME PHONE #:_____ CELL PHONE #_____ WORK PHONE #_____

EMERGENCY CONTACT (other than parent):_____ RELATION TO CHILD:_____

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE#_____

STUDENT'S DOCTOR:_____ DOCTOR'S PHONE #:_____

STUDENT'S DENTIST:_____ DENTIST'S PHONE #:_____

**DOES THE STUDENT HAVE: ASTHMA SEIZURES DIABETES CHRONIC ILLNESS SEVERE ALLERGIES**
**(*please fill out back of sheet AND call the school nurse*)**

**MEDICATION ALLERGIES: _____ FOOD ALLERGIES: _____**

DOES YOUR CHILD HAVE AN IEP OR 504 PLAN? ☐YES ☐NO

CURRENT MEDICATIONS**:**_____

SIGNIFICANT MEDICAL/SOCIAL HISTORY (Including injuries): _____

**PLEASE CHECK which of the following medications you WILL ALLOW your child to be given by nurse and state dosage if necessary. Doses not specified will be given according to the child's age and weight according to BRDHD's medical director's order.**

| | | | |
|---|---|---|---|
| ☐Acetaminophen (Tylenol) | ☐Ibuprofen (Advil/ Motrin) | ☐Cough Syrup | ☐Cough drop |
| ☐Antacid (Tums or liquid) | ☐Anti-Nausea Medicine (Emetrol) | ☐Aloe Vera (for burns) | ☐Orajel |
| ☐Claritin (Loratidine – for allergies) | ☐Sore Throat Lozenge | ☐Calamine Lotion | |
| ☐ Bacitracin /Triple antibiotic cream | ☐ Hydrocortisone Cream | ☐Sun Screen | |

**Additional instructions**: _____

***IF THIS INFORMATION SHOULD CHANGE, PLEASE NOTIFY THE SCHOOL NURSE, IMMEDIATELY.***

**CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS** (Valid for school year listed above)
I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include screenings such as vision, hearing, scoliosis, and dental screenings, physical exam, treatment, first aid, over the counter medication as indicated above, and any other health service given to my child by staff or agents of the Barren River District Health Department. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I like-wise release the staff from any liability related to the administering of the above medications to my child as long as the responsibility is discharged according to the above instructions. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a healthcare worker is exposed to his/her blood, body fluids or tissue. I authorize the school health clinic to release and receive medical information about my child, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share pertinent medical information (history of allergies or significant medical history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I also give permission for school health clinic staff to view my child's Individual Education Plan (IEP). Further, I understand that information obtained during school physicals and immunization information will be released to my child's school. I request that payment of authorized medical insurance benefits be made to Barren River District Health Department on my behalf, for services my child receives. I also authorize the local health department to release medical information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Barren River District Health Department's Privacy Notice.

I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

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| _____ | _____ | _____ |
|---|---|---|
| (Signature of Custodial Parent/Guardian) | (Printed Name of Custodial Parent/Guardian) | (Date Signed) |

Parent e-mail address (may be used if immediate attention is not needed):_____