

Tishomingo County School District
 Medical Policy and Consent Form 2024-2025

Student: _____ Birthday: _____ Grade: _____ Teacher: _____

Parent/ Legal Guardian Contact Information

Mother/Guardian: _____ Father/Guardian _____
 Employer _____ Employer _____
 Main phone _____ Main phone _____
 Work phone _____ Work phone _____

If unable to reach parent/ guardian contact:

Name	Relationship to Student	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Child's Physician: _____ Phone: _____

“Over-the-counter” medications are available from the school nurse only if a standing order form is completed and on file from a physician. Over the counter medications will not be given before 10:00 a.m. or after 2:00 p.m. If medications are needed, the school nurse will call for you to bring medication and continue to monitor your child as necessary.. Students are not allowed to bring medications to school or keep any medications with them at school (*Exception- see below). If your child requires prescription medications or other medications not available from the nurse, you and your child’s physician must complete the Authorization for Medication at School form. All medications must be brought to school by parent/guardian in the original pharmacy container. (Pharmacists will provide an extra container if requested)

X _____
 Parent/ Legal Guardian Signature _____ Date _____

**Students may keep Asthma Inhalers, Diabetic Medications/ Supplies, and Epi-Pens with them at all times if so ordered by the attending physician. If so, you and your child’s physician must complete the required form and/ or care plan related to your child’s specific diagnosis listed above. All of this required paperwork must be returned to the school nurse to be kept on file in the student’s school health record. If you have any questions, please contact the school nurse.*

**In accordance with the “MS Asthma and Anaphylaxis Child Safety Act” Tishomingo County School District will maintain a supply of auto-injectable epinephrine (EpiPen) at each school to be administered to a student when the school nurse or trained school employee, in good faith, believes is having an anaphylactic reaction, whether or not the student has a prescription for epinephrine.*

By signing this form, I give consent for my child to receive medical care/treatment, medication administration, first aid, or other needed emergency intervention by school personnel. In the event of an extreme emergency requiring an ambulance, I understand I am responsible for costs incurred. I also acknowledge that I have read and understand all statements on this form regarding medication administration, including emergency EpiPen administration, at school and required forms to be turned in to the school nurse. I understand that I am responsible for turning any required forms needed into the school nurse. I also give my permission for my child to have health screenings including hearing, vision, height, weight, blood pressure, and scoliosis. (Head lice screenings are not optional and will be done periodically throughout the school year.)

X _____
 Parent/ Legal Guardian Signature _____ Date _____

Tishomingo County School District Student Health Record 2024-2025

Student: _____ Grade: _____ Teacher/ Homeroom: _____

Does your child have any of the health conditions listed below? <i>(Please only mark what applies to your child)</i>		<input type="checkbox"/> Male <input style="margin-left: 100px;" type="checkbox"/> Female
<input type="checkbox"/> ALLERGIES *Please list allergies below: <input style="margin-left: 100px;" type="checkbox"/> No Known Allergies	<input type="checkbox"/> SURGICAL HISTORY	
Are any of the allergies above severe allergies requiring the use of an EpiPen and/or other medications? Yes _____ No _____		
<p style="color: red; font-size: small;">★ If yes, the Allergy Emergency Treatment Plan will need to be completed by you and your child's Physician. Also, food allergies require the Medical Statement Non-Disabled Child form for needed adjustments in the school nutrition program.</p> <p style="color: red; font-size: small;">★ Please note that in accordance with the Americans with Disabilities Act service dogs will be allowed on all TCSD campuses to assist children with medical conditions or disabilities.</p>		
<input type="checkbox"/> ASTHMA <i>(current diagnosis)</i> <ul style="list-style-type: none"> If so, does your child use an inhaler? Yes _____ No _____ Will your child need his/ her inhaler at school? Yes _____ No _____ Asthma medications used: _____ <p style="color: red; font-size: small;">★ In accordance with S.B. 2218 "MS Asthma and Anaphylaxis Child Safety Act" ALL students with asthma are required to have a current Asthma Action Plan on file that has been completed by the child's physician.</p>	<input type="checkbox"/> SEIZURES <ul style="list-style-type: none"> If so, does your child use seizure medication? Yes _____ No _____ Seizure medications used: _____ Will medication need to be given at school? Yes _____ No _____ <p style="color: red; font-size: small;">★ If yes, the Authorization for Medications at School form will need to be completed by you and your child's Physician.</p> <ul style="list-style-type: none"> Is emergency medication prescribed? Yes _____ No _____ <p style="color: red; font-size: small;">★ Seizure Care Plan is required.</p>	<input type="checkbox"/> HEART CONDITIONS <ul style="list-style-type: none"> Current diagnosis: _____ Medications for condition: _____ Will medication need to be given at school? Yes _____ No _____
<input type="checkbox"/> DIABETES <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <ul style="list-style-type: none"> If so, does your child use insulin? Yes _____ No _____ Insulin pump? Yes _____ No _____ Continuous glucose meter? Yes _____ No _____ Oral diabetic medications used: _____ <p style="color: red; font-size: small;">★ Diabetes Medical Management Plan will need to be completed.</p>	<input type="checkbox"/> ADHD <ul style="list-style-type: none"> If so, does your child take medication? Yes _____ No _____ ADHD medications used: _____ Will medications need to be given at school? Yes _____ No _____ <p style="color: red; font-size: small;">★ If yes, the Authorization for Medications at School form will need to be completed by you and your child's Physician.</p>	<input type="checkbox"/> STOMACH CONDITIONS <ul style="list-style-type: none"> Current diagnosis: _____ Medications for condition: _____ Will medication need to be given at school? Yes _____ No _____

Please check if any of the following conditions apply.

- History of head injury
- Hearing problems
- Vision Problems
- Dental problems
- Eating disorder
- Muscle/bone problems
- Sickle Cell disease
- Bleeding disorder
- Kidney disease
- Bladder problems
- Nosebleeds
- Cystic fibrosis
- Migraines
- Depression
- Anxiety
- Behavioral concerns

*School counselors will be notified accordingly for mental health concerns.

None of the above apply to my child

Does your child see a specialist? Please list the name and contact number for them.

Are there any other conditions the school nurse needs to know about to care for your child?

Are there any other medications your child takes regularly or as needed that are not listed above?