School Health Services Consent

HOMEROOM TEACHER:_____________________ GRADE:________ LANGUAGE(S) SPOKEN AT HOME:______________________________

CHILD'S LEGAL NAME________________________ BIRTHDATE:________________ RACE:__________ MALE___ FEMALE___

CHILD'S SOCIAL SECURITY NUMBER:_____________________________________

ADDRESS: ____ CITY/STATE/ZIP ______________________________________

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

PARENT/GUARDIAN NAME:______________________________________ RELATIONSHIP TO CHILD:_______________________

HOME PHONE #______________________ CELL PHONE #______________________ WORK PHONE# _______________________

PARENT/GUARDIAN NAME:______________________________________ RELATIONSHIP TO CHILD:_______________________

HOME PHONE #______________________ CELL PHONE #______________________ WORK PHONE# _______________________

EMERGENCY CONTACT (other than parent):__________________________RELATIONSHIP TO CHILD:_______________________

HOME PHONE #______________________ CELL PHONE #______________________ WORK PHONE# _______________________

MEDICATION ALLERGIES:____

_____ RED DYE ALLERGY _____ LATEX ALLERGY _____ CANNOT SWALLOW PILLS

PLEASE CHECK which of the following medications you WILL ALLOW your child to be given by nurse. Doses will be given according to the child's age and weight according to medical director's order. Medications are not dye-free and those with an * contain red dye and will not be administered to anyone stating they have a red dye allergy.**

_____ Acetaminophen (Tylenol)*** _____ Ibuprofen (Advil/Motrin) _____ Orajel*** _____ Hydrocortisone Cream _____ Calamine Lotion

_____ Antacid*** _____Anti-Nausea Medicine *** _____ Antihistamine for allergy symptoms _____ Bacitracin Ointment

_____ Sun Screen _____Aloe Vera (for burns) _____ Sore Throat Lozenge/ Cough Drop*** _____ Cough Syrup ***

Any medications checked will be administered, as per your consent, without contact from the school nurse. A copy of the nurse's notes will be sent home to the parent/guardian stating what medications were given, dosage, and time. It is the child's responsibility to get this copy to the parent/guardian. The school nurses cannot take consent to give medications over the phone.

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, and dental screenings, physical exams, treatment, first aid, over the counter medication as indicated above, and any other health service given to my child by Med Center Health. 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 health care 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 Act of 1996 (HIPPA), 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 authorize Med Center Health 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 Med Center Health'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.

____ ____ ____________________

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