Madison County School District
School Health Clinic

The mission of the Madison County School District School Health Clinic is to protect the health and well-being of all students, thereby promoting student success.

Clinic days and times vary from school to school.

Contact your child's school to learn the nurse's clinic schedule.

The following is available to all students whose consent forms have been signed:

Nursing Assessment of health problems with referral to Local Health Care Provider as needed

Over the Counter GENERIC medication as follows:

Benadryl (Generic) for allergic reaction/itching. **Antacid tablets or liquid** for indigestion or stomach upset. **Robitussin** (Generic) for cough associated with common cold. **Ibuprofen** (Generic Advil, Motrin) for headaches, cramps and other discomfort based on nurse's assessment. **Acetaminophen** (Generic Tylenol) for headaches, earaches and other discomfort based on nurse's assessment.	**Hydrocortisone cream** (1/2%) for skin rash **Antifungal cream** for ringworm or other fungal rash **Aloe Vera lotion** for mild sunburn or skin irritation **Antibiotic ointment** for cuts, abrasions and other skin conditions based on the nurse's assessment. **Calamine lotion** for contact skin rashes.

Health Assessments:

Nursing assessment of health complaints, nursing management, and referral as needed
Hearing screenings
Dental screenings
Vision screenings
Immunization outreach and follow-up

Health Education Services:

Physical health problems
Physical and Dental Health Education for students and parents
Classroom instruction per request as time allows

Emergency Action Plan (EAP) *** PLEASE CONTACT YOUR SCHOOL NURSE IF NEEDED:**

1. **DIABETES**
2. **ASTHMA** that requires the use of a nebulizer or inhaler
3. **SEIZURES**
4. **ALLERGY** (food allergy, bee sting allergy, or any allergy requiring the use of antihistamines or EPI-PEN)

Confidentiality:

All medical records are the property of the Madison County School District and protected under FERPA.
No other agency will have access to these records without your written consent.
We protect the privacy of your child's health information by:

- Limiting how we use and disclose health information.
- **Providing physical safeguards including secure offices and** storage facilities, electronic protections, and procedures.
- Training employees about privacy policies and procedures.

(8-23)

↓Tear on Dotted Line and Return to School↓

Please Return to School

Consent for School Health Services
Madison County School District
CHILD / STUDENT INFORMATION

Reviewed by: _____ **Entered:** ☐

MCSD 246 **Outreach:** ☐ **Initials:** _____

Grade _____ Team _____ Homeroom Teacher _____

Child's Last Name _____ First Name _____ MI ____
(Please give child's complete legal name)

Child's Birthdate _____ ☐Male ☐Female

Street Address _____ City _____ Zip _____

Mother _____ Phone #1 _____ #2 _____

Father _____ Phone #1 _____ #2 _____

Legal Guardian _____ Phone #1 _____ #2 _____

Emergency Contact Person OTHER than guardian or parent _____

Emergency Contact Person Phone #1 _____ #2 _____

Has your child EVER attended a Madison County School? ☐Yes ☐No

If YES. what SCHOOL(s) did student attend in the past? _____

Child's Medical History:

Important medical history the nurse should know about: _____

☐Anxiety ☐ADHD

Medications Taken Daily _____

Is your child ALLERGIC to: (check only if apply)

☐ **Medications:** EXPLAIN REACTION _____

☐ **Peanuts or other NUTS:** EXPLAIN REACTION _____

☐ **Bee/Wasp Stings:** EXPLAIN REACTION _____

☐ **OTHER:** EXPLAIN REACTION _____

Child's MEDICAL Insurance:

Does your child have a KY Medicaid Card? ☐**Yes** ☐**No** Number _____

My child **HAS** the following ***life threatening condition*** that may need **EMERGENCY ACTION PLAN or MEDICATION (EPI-PEN, Glucagon, Diastat, Asthma Inhaler, etc...)** at school:
☐**Diabetes** ☐**Asthma** ☐**Seizures** ☐**Severe Allergies** ☐**Other** _____

Child's Health Care Provider: _____ **Child's** Dentist _____

Consent for Health Services

I consent to care for my child that may include screening, exam**s, assessments, treatment, first aid, over**-the-counter medicine, as listed on **MCSD-SHC 1**, and any other health service given to me/my child by staff of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to receive and release medical/dental and immunization information about my child to his/her individual school, health care provider, immunization registry, or dental provider as needed or requested. If my child has Medicaid, I also authorize the school clinic to release this information to Medicaid so that the Medicaid may be billed for visits to the school clinic. I also understand by signing this consent, I acknowledge that I have access to the Madison County Schools Privacy Notice, either or the district website or I can be provided with a copy if requested.

Signature: _____ **Date:** _____
(Parent/Legal Guardian/Emancipated Student) (EXPIRES AFTER CURRENT SCHOOL YEAR)

(8/23)