Last School Attended _____

Elementary 2022-2023
Richland County School District One

CONFIDENTIAL HEALTH QUESTIONNAIRE FOR SCHOOL NURSE ONLY

STUDENT NAME_____ BIRTHDATE ____/____/_____

MALE ☐ FEMALE ☐ RACE_____ GRADE _____ HOMEROOM TEACHER _____

ADDRESS_____
ZIP CODE_____ HOME PHONE_____

STUDENT LIVES WITH (CIRCLE ONE): MOTHER FATHER BOTH PARENTS OTHER_____

MOTHER/ LEGAL GUARDIAN'S NAME _____EMPLOYER _____
WORK NUMBER_____ CELL PHONE_____ E-MAIL _____

FATHER/ LEGAL GUARDIAN'S NAME _____EMPLOYER _____
WORK NUMBER_____ CELL PHONE_____ E-MAIL _____

STEP PARENT (living with child) NAME _____ PHONE # _____

LIST THE NAME(S) OF ANY SIBLINGS AT PRESENT SCHOOL: _____

HEALTH CARE PROVIDER/NURSE PRACTITIONER_____
TELEPHONE NUMBER_____ LAST PHYSICAL/VISIT _____
DENTAL CARE PROVIDER_____
TELEPHONE NUMBER _____ LAST VISIT _____ (RECOMMENDED CLEANING EVERY 6 MONTHS)
MEDICAID (CIRCLE ONE) Y / N POLICY NUMBER_____
PREFERRED HOSPITAL_____

LIST 2 AUTHORIZED PEOPLE TO ASSUME RESPONSIBILITY AND PICK UP YOUR CHILD IN CASE OF AN ILLNESS/EMERGENCY WHEN THE PARENT/GUARDIAN CANNOT BE REACHED

1. NAME _____RELATIONSHIP TO STUDENT _____
   PHONE NUMBER (WORK)_____(HOME)_____ (CELL)_____
   ADDRESS_____

2. NAME _____RELATIONSHIP TO STUDENT _____
   PHONE NUMBER (WORK)_____(HOME)_____ (CELL)_____
   ADDRESS_____

(PLEASE COMPLETE THE BACK OF THIS FORM) OVER

Reviewed By: _____ Date: _____ School Year: _____

Revised 5/2014

Please check (V) and explain any health conditions DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER (Doctor or Nurse Practitioner)

Check	Condition	Explain
	ADD/ADHD	(CURRENT MEDICATION):
	ALLERGIES SEVERE REQUIRING AN EPI-PEN (Extra should be kept at school)	☐ Food: ☐ Insects: ☐ Seasonal:
	ANEMIA (LOW BLOOD)	
	ASTHMA (Inhaler should be available at school with completed medication forms on file)	Medication: Last Attack: ____/___/_____
	BLADDER/URINARYCONDITION	
	BONE/ORTHOPEDIC CONDITION	
	DIABETES (SUGAR)	Medication:
	EPILEPSY(SEIZURES)	Last Episode: ____/___/_____ Medication:
	FAINTING SPELLS (Syncope)	
	GENETIC CONDITION	
	HEART TROUBLE	Corrected: Y / N
	HEMOPHILIA/BLEEDING DISORDER	
	HIGH BLOOD PRESSURE	
	MENTAL HEALTH ILLNESS	DIAGNOSIS:
	PROBLEMS WITH VISION	GLASSES: Y / N - LAST EXAM: ____/___/_____
	PROBLEMS WITH HEARING	HEARING AID: Y / N EAR: ☐ RIGHT ☐ LEFT
	REACTIVE AIRWAY DISEASE	
	SICKLE CELL	Last Crisis: ___/__/___ Last Hospitalization: ___/___/___
	SICKLE CELL TRAIT ONLY	
	SKIN DISORDER	
	TUBERCULOSIS (TB)	
	OTHER:	

Does your child take any daily medications? ☐ No ☐ Yes – List medication and dosage:

_____

_____

_____

Medication given at: ☐ Home ☐ School ☐ Only in Emergency

When possible, the parent/legal guardian should arrange for the student to receive medication before or after school hours.

Medication should be brought to the health room in its original container and the appropriate forms should be completed prior to a student receiving medicine at school. Parental consent is required for non-prescription medication and both parental and student's healthcare provider signatures are required for prescription medication. Students that will self-medicate/carry his or her meds while at school (i.e. albuterol inhaler) should have a **"parental release"** and **"self-medicating and/or self-monitoring"** forms completed by the parent, health care provider and student.

I GIVE THE SCHOOL NURSE PERMISSION TO CONTACT THE LICENSED PRESCRIBER AND/OR SHARE THE ABOVE INFORMATION WITH SCHOOL STAFF AND DISTRICT STAFF AS NECESSARY FOR MEETING MY CHILD'S EDUCATIONAL NEEDS.

PARENT/ LEGAL GUARDIAN'S SIGNATURE _____ DATE _____

RICHLAND ONE

ENGAGE • EDUCATE • EMPOWER

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AND FOR MEDICAID REIMBURSEMENT

PURPOSE: *This is an updated Medicaid Form that asks for your consent to share necessary information to verify Medicaid eligibility and to bill for school-based Medicaid reimbursement with Richland County School District One. When the district verifies Medicaid eligibility or bills for school-based services based on your child's eligibility for public benefits, it* ***DOES NOT*** *affect or impact health insurance or other Medicaid covered services that are provided to your child or family outside of school.* ***Please review, sign and return to school with your child within three days of receipt of this form.***

Richland County School District One (the District) and the South Carolina Department of Education have my permission to provide health-related services to my child and to release and exchange medical, psychological, and other personal identifiable confidential information, as necessary, to the Department of Health and Human Services and any third party insurance carrier regarding health-related services provided to my child. I understand that the purpose of this consent is to bill Medicaid or other health insurance for services under Part B of the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the South Carolina Department of Education my permission to bill Medicaid and any third party insurance and receive payment from Medicaid or any third party insurer for health-related services set forth in my child's individualized education program (IEP), and for psychological evaluation services, nursing services, and other health-related treatment services billable to Medicaid without the requirement of an IEP. I understand that the District and the South Carolina Department of Education have provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to accessing Medicaid or any third party insurance benefits and prior to this consent for release of information to bill Medicaid.

I further understand that the District and the South Carolina Department of Education will provide me annual written notification of my rights before Medicaid accesses my child's benefits to pay for services under the IDEA and that this consent for release of information to bill Medicaid is a one-time consent and is not required annually thereafter regardless of whether there is a change in the type or amount of services to be provided to the child or a change in the cost of the services to be charged to Medicaid or a third party insurance.

I understand that Medicaid reimbursement for health-related services provided by the District and the South Carolina Department of Education will not affect any other Medicaid services for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether I enroll my child in public or private benefits or insurance programs. I also understand that my refusal to allow access to the Department of Health and Human Services or any third party insurance carrier does not relieve the District of its responsibility to ensure that all required services are provided at no cost to me.

I understand that the granting of consent is voluntary on my part and may be revoked at anytime.
If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

I also understand that the District and the South Carolina Department of Education will operate under the guidelines of Part B of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of health-related services.

Student's Name _____ Student's Date of Birth _____

Medicaid # _____ Social Security # _____

Signature of Parent/Guardian _____ Date _____

WHITE – Student's Health Folder YELLOW – Medicaid Quality Assurance Monitor