

# MONTGOMERY COUNTY SCHOOL HEALTH CONSENT FOR SERVICES 2024-25

IHP/Emergency Plan? ☐ Y ☐ N

Reviewed by: \_\_\_\_\_

Student last name: \_\_\_\_\_ Student first name: \_\_\_\_\_ MI \_\_\_\_\_ GRADE: \_\_\_\_\_

Legal Street Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#1 Legal Guardian Name \_\_\_\_\_ Contact # ( ) \_\_\_\_\_ Contact # ( ) \_\_\_\_\_

#2 Legal Guardian Name \_\_\_\_\_ Contact # ( ) \_\_\_\_\_ Contact # ( ) \_\_\_\_\_

Student's Health Care Provider: \_\_\_\_\_ Student's Dentist: \_\_\_\_\_

**\*Health Conditions that may require EMERGENCY MEDICATION or Treatment at school:**

☐ Diabetes ☐ Asthma ☐ Seizures ☐ Severe Allergies to: \_\_\_\_\_

**Other conditions and/or current daily medications:** \_\_\_\_\_

**\*The district has stock Benadryl, Epi Pens and Albuterol @ each school for Life Threatening Emergencies**

A student may not carry ANY medication with them UNLESS written permission from their health care provider and/or parent --for OTC meds--is provided on a health plan. Prescription meds **GIVEN DAILY** must have written authorization of prescribing healthcare provider on form 09.2241 AP.21

## Consent for Health Services

By signing, I consent to care for my child that may include, but is not limited to, illness/injury assessments, medication administration, first aid, monitoring/education for chronic disease such as asthma or diabetes and/or referrals for further medical assessment. I consent for my child's immunization data to be entered into the KYIR registry to ensure a complete history. The school nurse ensures health screenings are completed including height, weight, vision & hearing as needed, and that I will be notified of any abnormal findings.\*To ensure student safety, school health services may share or request educationally relevant health information with school staff or medical professionals (MD, PA, NP, Dentist, etc...) having direct involvement with my child, or may contact the healthcare provider for necessary health information or medication and treatment clarification. A school nurse or trained staff member, in accordance with the Kentucky Department of Education and Montgomery County School Health Protocols, may provide basic comfort measures such as **saltine crackers, peppermint disks or soft peppermint** as age appropriate after she/he has evaluated my child's complaint. The health unit also has first aid items, including but not limited to **eye wash/artificial tears, aloe vera gel & Vaseline.**

### MARK THROUGH ANY COMFORT MEASURES YOU DO NOT WANT YOUR CHILD TO RECEIVE

The school **DOES NOT PROVIDE MEDICATION FOR STUDENTS**, however if you, the undersigned legal guardian, **wish to send in over-the-counter medication to be kept locked in the health unit** and administered as needed, per your directions, by the school nurse or other trained staff for designated complaint (s) please complete the following:

OTC Medication: _____	Given For: _____	Dosage: _____
Date Received from guardian: _____	Person receiving the medication: _____	
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Date Received from guardian: _____	Person receiving the medication: _____	

Must be in the original container, given to the nurse or staff member designated to provide health services or the supervising teacher/sponsor/coach for proper storage. (Includes field trips). Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read.

**By signing this consent, I release Montgomery County Schools from any liability related to the administration of medications or treatment as long as reasonable and customary care is given. This consent is given voluntarily and with full knowledge of its significance.**



\_\_\_\_\_  
Parent/Legal Guardian Signature\*

\_\_\_\_\_  
Relationship to student

\_\_\_\_\_  
Date

Consent valid for current school year only

Revised 5/9/24