SCOTT COUNTY SCHOOLS

Student Health Information Sheet 20__- 20__

Scott County Schools Health Services Division 2168 Frankfort Pike Georgetown, KY 40324

Student Name: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Student's Health Care Provider: _____ Phone: _____

Student's Medical History

1. Significant Medical History/Medical Diagnosis/Hospitalizations/Injuries:
   _____
2. Medication Allergies: _____ Food Allergies: _____
3. Medications Taken Daily: _____
4. Prescription Medication to be Given at School (must complete Medication Consent Form prior to administration at school): _____
5. Does your student have any of the following **Life-Threatening** conditions that may require **EMERGENCY** treatment or medications to be given at school? (additional paperwork will be requires including medication consent form, emergency action plan and individual health plan)

Diabetes (glucagon) Asthma (inhaler) Seizures (Diastat) Severe Allergy (Epi-Pen)

Insurance Information

Health Insurance Provider: _____ Employer: _____

Policy Number: _____ Group Number: _____

Emergency Treatment Authorization/Consent for Health Services

I, the undersigned, hereby authorize officials of Scott County Public Schools to contact the person named above and do authorize the named physician or EMS personnel to render treatment as may be deemed necessary in an emergency, for the health of the named child. In the event the parent/guardian, physician, or other persons named on this form cannot be contacted, officials of Scott County Public Schools are hereby authorized to take whatever action is deemed necessary, in their judgement, for the health of said child. I will not hold the school district financially responsible for the emergency care and/or transportation of said child. Signing this form shall release Scott County Public Schools and staff members from any liability of any nature in assisting during a medical emergency.

I, the undersigned, authorize the school health clinic to receive and release medical/dental, and immunization information about my child to his/her individual school's administrators, teachers, therapists, social workers, primary care physicians, immunization registry, or dental provider as needed or requested for purposes of treatment and care coordination.

I, the undersigned, give my consent for the SCS healthcare professional staff or delegated trained personnel to provide care to my child including, but not limited to, first aid, vision and dental screenings, exams, assessments, treatment and any other health services needed.

Parent/guardian signature: _____ Date: _____

PLEASE COMPLETE OTHER SIDE

Revised 7/24/24 cr

OVER-THE-COUNTER (OTC) MEDICATION PERMISSION FORM

Student Name	Teacher	DOB

As the parent/ legal guardian of the above-named student, I authorize the school nurse or designee to give my child non-prescription, over-the-counter (OTC) medications during the school year in accordance with the Scott County School Medication policy as the need arises. ***NO VERBAL PERMISSION WILL BE ACCEPTED***

By initialing the below listed medications, I am certifying that my child has previously used or taken this medication at least ONE time.

YES	NO		YES	NO	
		Hydrocortisone Cream			Saline Eye Drops
		Oral Diphenhydramine (Benadryl)			Petroleum Jelly (Vaseline)
		Calamine Lotion			Wound Spray, Saline
		Antibiotic Ointment (Bacitracin, Neomycin Sulfate, Polymyxin Sulfate)			Cough Drops
		Sunscreen			Aloe Vera Gel
		Acetaminophen			Ibuprofen
		Sting Relief			Antacid Tablets (Tums)

- The nurse will use professional judgement to determine whether to administer any medication listed above that has been initialed and signed by parent/guardian.
- The nurse has a right to refuse to administer any medication she believes is not in the best interest of the student due to dosage, side effects or any other concerns.
- The above listed medications MAY BE PROVIDED by the school your student attends and if so, will be age appropriate, and will be administered according to the manufacturer's label.
- If students are noticed to request medications more than twice a week, the parent/guardian will be notified so further investigation or action can be implemented.
- OTC medications will not be administered more than three consecutive days without a physician's order.
- Permission for OTC medications will need to be renewed each school year.
- Parent/Legal guardian may WITHDRAW signed permission with a written request at any time.
- Refer to medication policy for full disclosure and instructions

MEDICATION HISTORY:

Is your student allergic to any OTC medications? ____YES ____ NO

If YES, please list medication and reaction: _____

_____

I hereby give my permission for the above initialed non-prescription medications to be administered to my child as needed by the school nurse or designee. I certify my child has taken/used this medication previously with no known adverse reactions. I will NOT hold the school staff responsible for any undesired reaction that may occur from the administration of said medications.

Parent/Legal Guardian Signature_____Date:_____

_____

School Nurse/Date

PLEASE COMPLETE OTHER SIDE