

# 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 nurses' 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:**

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| <p><i>Benadryl</i> (Generic) for allergic reaction / itching.<br/> <i>Antacid tablets or liquid</i> for indigestion or stomach upset.<br/> <i>Robitussin</i> (Generic), for cough associated with common cold.<br/> <i>Ibuprofen</i> (Generic Advil, Motrin) for headaches, cramps and other discomfort based on nurses assessment.<br/> <i>Acetaminophen</i> (Generic Tylenol) for headaches, earaches and other discomfort based on nurses assessment.<br/> <i>Loratadine</i> (Generic) for sneezing, itchy watery eyes and throat, runny nose</p> | <p><i>Hydrocortisone cream</i> (1/2 %) for skin rash<br/> <i>Antifungal cream</i> for ringworm or other fungal rash<br/> <i>Aloe Vera Lotion</i> for mild sunburn or skin irritation<br/> <i>Antibiotic ointment</i> for cuts, abrasions and other skin conditions based on the nurse's assessment.<br/> <i>Calamine lotion</i> for contact skin rashes.</p> |
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**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 Plans (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)
5. **Other EAP's for other special health conditions as needed.**

**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.

**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** Birth Date \_\_\_\_\_  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 \_\_\_\_\_

**Child's MEDICAL Insurance:**

Does your child have a KY Medicaid Card  Yes  No Number \_\_\_\_\_

**Child's Medical History:**

Medical Diagnosis ADHD Medication \_\_\_\_\_  No Medication

Medical Diagnosis Anxiety Medication \_\_\_\_\_  No Medication

**IMPORTANT** medical diagnosis the nurse should know about: \_\_\_\_\_

Medications taken **EVERY DAY:** \_\_\_\_\_

**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: \_\_\_\_\_

My child HAS a medical diagnosis of the following ***life threatening condition(s)*** that may need **EMERGENCY TREATMENT or MEDICATION (EPI-PEN), Glucagon, Diastat, Asthmas 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, exams, 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 on the district website or I can be provided with a copy if requested.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent /legal guardian / emancipated student) (EXPIRES IN ONE YEAR) MCSD-SHC 2 (08/25)

Tear On Dotted Line and Return to School