

Sequatchie County Schools

School Nurse Record 2019-2020

Student Name: _____

School: _____ Grade: _____

Emergency Contact: _____ Phone: _____

Physician Name: _____ Phone: _____

Welcome to school! Please fill out the following information and return this form to school for your nurse. All information is confidential and will be kept in the Health Office.

Does your child take medication on a daily basis? Yes ___ No ___

Name of medication _____ Dose: _____ Time given: _____

Is this medication to be administered at school? Yes ___ No ___ (If yes, contact nurse immediately)

HEALTH HISTORY:

Please review the following conditions and check "yes" if they apply to your child and explain.

Diabetes: Yes ___ No ___ If yes, please indicate what kind of diabetes: _____

Type 1 (requires insulin) ___ Type 2 (controlled by diet) ___

Allergies: Yes ___ No ___ If yes, please check what kind of allergies:

Environmental (example: bees) _____

Medication: (example: penicillin) _____

Dietary: (example: peanuts) _____

Allergies that require an EpiPen: Yes ___ No ___ If yes, will an epiPen be provided for school? _____

Seizures: Yes ___ No ___ If yes, are you on daily medications? _____

If yes, have you ever been prescribed DiaSTAT? _____

Glasses: Yes ___ No ___ If yes, at all times or for reading? _____

What was the date of your child's last visual exam? _____

Hearing difficulties/infections: Yes ___ No ___ Explain _____

What was the date of your child's last hearing exam? _____

Asthma: Yes ___ No ___ If yes, will inhaler be provided for school? _____

Heart Trouble: Yes ___ No ___ If yes, please explain _____

What is the date of your child's last physical exam, or pending appointment date? _____

Any other health concerns? (physical limitations, diseases, special accommodations, behavioral issues, etc)

Please continue to keep us informed of any changes in your child's health status, medication or immunization dates.

CONTINUED ON THE BACK

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CONSENT FOR FIRST AID TREATMENT:

Consent for First Aid treatment will allow appropriate treatment for your child in the event of a minor illness or injury. If you do not give us your permission to provide these non-emergency treatments, we will not be able to provide them to your child unless you come to the school and sign a separate form. Conditions in parentheses are examples of the most frequent use of these medications, but may not be the sole use of the medication. If your child begins to use these medications frequently, it will be your responsibility to provide the school with the medication. Please contact your school nurse for any questions.

Please check all that apply:

- Bausch and Lomb® or generic equivalent (*eye irritation*)
- Benadryl® cream or generic equivalent (*rash or bee sting*)
- Calamine lotion/Caladryl® or generic equivalent (*sunburn or poison oak/ivy*)
- Hydrocortisone® ointment or generic equivalent (*insect bites*)
- Neosporin® or generic equivalent (*topical treatment for cuts*)

Medications are not administered at school without a written permission from parent. If it is necessary for your child to receive medication at school on a daily basis, an adult must bring the medication into the school in its original bottle. (This includes Tylenol, Advil, Motrin, Benadryl, etc.) and fill out the appropriate paperwork. If it is necessary for your child to receive a prescription medication, a physician order and written permission from a parent is required and the medication must be brought in by the adult in the original bottle. A photo ID is required to pick up prescription medication.

Would you like to be notified when your child is given any of the above medications?

Yes: please provide best contact number: _____

No: _____

CONSENT FOR MEDICAL TREATMENT:

In an emergency situation where School Health Care Professionals (or employees) deem the situation an emergency, 911 will be called. As the parent or legal guardian, I understand my child will be transported to the nearest emergency room and all attempts will be made to contact me during this time. I give my permission for my child to receive treatment at the hospital they are transferred to in an emergency situation.

Parent/Legal Guardian name printed: _____

Parent/Legal Guardian Signature: _____

Date: _____