

Student: _____	/	/	/
(LAST NAME)	(FIRST NAME)	(DATE OF BIRTH)	(GRADE/SECTION)

MALE
 FEMALE
 SCHOOL YEAR _____ FOR THE SCHOOL NURSE

EMERGENCY CONTACT INFORMATION

PAGE 1 OF 2

Parent/Guardian:

Name _____	Relationship _____	Work Phone _____	Home Phone _____	Cell Phone _____
Street Address _____	City _____	Zip _____	e-mail _____	
Mailing Address (if different from Street Address) _____	City _____	Zip _____		

Parent/Guardian (if different from above):

Name _____	Relationship _____	Work Phone _____	Home Phone _____	Cell Phone _____
Street Address _____	City _____	Zip _____	e-mail _____	

Please list below three people who have your permission to pick your child up from school and make decisions concerning your child in the event that you cannot be reached.

<u>Name of Person</u>	<u>Relationship</u>	<u>Telephone</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

My Child's medical care is provided by:

Doctor's Name _____ **Phone** _____

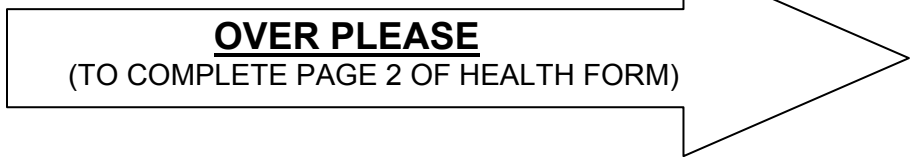
Hospital Choice _____ **Health Insurance Policy #** _____

In case of an emergency, the school staff will contact 911. Every attempt will be made to contact a parent, a guardian, or a designated emergency contact. In case of accident or serious illness, the school has my permission to contact and follow the instructions of the above physician. If this physician is not available, I authorize care and treatment for my child by any physician and/or hospital. I will assume responsibility for the emergency care and/or transportation for said child.

Parent / Guardian Signature: _____ **Date:** _____

Health Screenings: CCSD School Nurses follow DHEC recommendations for vision, hearing, blood pressure, height / weight, scoliosis and dental screenings as time permits.

Contact your child's school nurse if you have questions regarding screening.



Student: _____ / _____ / _____ / _____
 (LAST NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

MALE **FEMALE** **SCHOOL YEAR** _____ **FOR THE SCHOOL NURSE**
CONFIDENTIAL (FOR SCHOOL NURSE ONLY) **PAGE 2 OF 2**

Please complete the information below. In order for your child to receive medication or a medical procedure at school, you must provide a completed *Doctors Order Form* available from the school nurse or online at:

http://www.ccsdschools.com/Departments_Staff_Directory/Academic_Division/HealthServices/

My child has the following:

- ADD/ADHD**Medication _____
- Allergies**.....Type _____ Medication _____
- Asthma**.....Medication/Treatment _____
- Diabetes** Insulin Pump Injections Oral Medication Blood Glucose Checks
- Seizure Disorder**.....Medication _____
- Psychiatric Disorder**...Type _____ Medication _____
- Sickle Cell Anemia**.....Medication/Treatment _____
- Physical Disability**.....Type _____ Medication/Treatment _____
- Hearing Problems**..... Hearing Aids Cochlear Implant
- Vision Problems** Glasses Contacts
- Other** _____

HEALTH CONSENTS:
 (Please address each Yes / No Question)

Over the Counter Medication (OTC): By checking “yes” below, the following Over the Counter medications may be administered by the school nurse only if your child meets the clinical policy criteria. Charleston County School District is under no obligation to provide OTC medications for students. Parents will be notified if the student frequently requests OTC medication.

<input type="checkbox"/> YES <input type="checkbox"/> NO	Acetaminophen (Like Tylenol) for headache, earache, fever (as determined by the policy), sore throat, orthopedic injuries, jammed fingers/toes, sprains, and strains.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Ibuprofen (Like Advil) for menstrual cramps, headache, earache, fever (as determined by the policy), sore throat, orthopedic injuries, jammed fingers/toes, sprains, and strains.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cough Drops (Like Halls) for cough with minimal congestion and upper respiratory infection.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Chewable Antacid (Like Tums) for nausea, abdominal pain, and upset stomach.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Liquid Antacid (Like Mylanta) for nausea, abdominal pain, and upset stomach.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hydrocortisone Cream for bites, stings, and rashes.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Topical Oral Anesthetic (Like Oragel or Anbesol) for toothache.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Antibiotic Ointment (Like Neosporin) for abrasions.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Anti-Fungal Cream for fungal skin infections.
<input type="checkbox"/> YES <input type="checkbox"/> NO	I give the nurse permission to exchange information with my child’s healthcare provider. All information will be kept strictly confidential and used only to provide appropriate individualized healthcare services for my child while in school.
<input type="checkbox"/> YES <input type="checkbox"/> NO	I give permission to release to Medicaid any information necessary for reimbursement of nursing services at no cost to me, the parent / guardian. I understand that this WILL NOT affect any services my child receives.

Parent / Guardian Signature _____ **Date** _____