School Nurse Health Information (Emergency Card)

MUST BE COMPLETED FOR STUDENT TO ATTEND FIELD TRIPS

Student:_____ _____ _____ _____ ☐ Male ☐ Female
(Last Name) (First Name) (Date of Birth) (Grade/Section)

EMERGENCY CONTACT INFORMATION

Parent/Guardian

Name _____ Relationship _____ Work Phone _____ Home Phone _____ Cell Phone _____

Street Address _____ City _____ Zip _____

Email Address _____ Occupation _____

Parent/Guardian (if different from above)

Name _____ Relationship _____ Work Phone _____ Home Phone _____ Cell Phone _____

Street Address _____ City _____ Zip _____

Email Address _____ Occupation _____

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.

Name of Person	Relationship	Telephone
1.		
2.		
3.		

Every school has a nurse assigned to them and first responders trained in CPR and First Aid. The nurse may not be on the school campus at all times. In the event of an emergency, the school staff will contact 911 and follow their instructions. Every attempt will be made to contact a parent, guardian, or a designated emergency contact.

Hospital Choice _____ Doctor's Name _____ Doctor's Phone _____

Insurance/Medicaid # | | | | | | | | | | |

I consent for a Charleston County School District (CCSD) nurse to provide routine and emergency medications following CCSD policy, accident and injury care (Non-IEP nursing services) for my child, release and exchange information about the service provided along with my child's name, date of birth, Medicaid or health insurance number, gender, and my contact information to the Medicaid Agency (Department of Health and Human Services), to bill and receive payment for the nursing services from the Medicaid Agency. I understand that Medicaid reimbursement for Non-IEP nursing services provided by CCSD will not affect any other Medicaid services for which my child is eligible. CCSD will continue to provide Non-IEP nursing services for my child at no cost to me even if I refuse to allow billing for services. Granting consent is voluntary and may be revoked at any time. Revocation is not retroactive. The District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of Non-IEP nursing services.

Parent/Guardian/Student (if 18) Print name _____

Signature _____ Date _____

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Student:_____ _____ _____ _____ ☐ Male ☐ Female
(Last Name) (First Name) (Date of Birth) (Grade/Section)

Medication/Medical Procedures: (CCSD policy JLCD-Assisting Students with Medications) Any prescription medication or medical procedure (blood sugar check, tube feeding) to be administered at school or school related activities must be accompanied by written orders from a health care practitioner. Limited over-the-counter medications may be administered by the school RN or LPN with parent consent. Complete consent below. All information below is confidential for the school nurse and may be shared on need to know basis for student safety.

Screenings: CCSD school nurses conduct vision, hearing, blood pressure, BMI and dental screenings, as time permits, based on DHEC recommendations. Contact your school nurse if you do not want your child to participate. Head Start and Early Head Start follow program requirements for vision, blood pressure, BMI, dental, lead and developmental screenings.

(OTC) Over the Counter Medication	Check or Initial Each	I consent for the Charleston County School District RN or LPN to administer the OTC medication as indicated below. Medication will be administered following the policy JLCD. _____ Ibuprofen _____ Acetaminophen _____ Tums _____ Cough Drops _____ Antibiotic Ointment _____ Hydrocortisone Cream _____ Anti-fungal Cream
Consent	☐ Yes ☐ No	I consent for the school nurse to exchange information with my child's health care provider in order to meet the health care needs of my child.

Health History

ADD/ADHD	☐ Yes ☐ No	☐ Takes Medication at Home ☐ Needs Medication at School:_____ ADD/ADHD Doctor's Name:
Allergy	☐ Yes ☐ No	☐ Environmental/Seasonal ☐ Takes Medication at Home ☐ Needs Medication at School:_____
Severe Allergy	☐ Yes ☐ No	☐ Severe (Life threatening) to: *_____* ☐ Emergency Medication (EpiPen/Auvi-Q) ☐ Does Not Have Epinephrine at School Last Date EpiPen Used ____/____/____ Allergy Doctor's Name:
Asthma	☐ Yes ☐ No	☐ Daily Maintenance Medication ☐ Rescue Inhaler ☐ Rescue Nebulizer ☐ Does Not Use/Have an Inhaler Asthma Doctor's Name:
Cardiac (Heart)	☐ Yes ☐ No	☐ Takes Medication at Home ☐ Needs Medication at School:_____ Heart Doctor's Name:
Diabetes	☐ Yes ☐ No	☐ Type 1 ☐ Type 2 ☐ Blood Glucose Checks ☐ Oral Medication ☐ Carb Counting ☐ Takes Insulin ☐ Shots ☐ Pump ☐ Glucagon Diabetes Doctor's Name:
Epilepsy (Seizures)	☐ Yes ☐ No	☐ Daily Medication ☐ Diastat ☐ Other Needs/Treatment ☐ Date of Last Seizure ____ /____ /____ Seizure Doctor's Name:
Sickle Cell Anemia	☐ Yes ☐ No	☐ Trait ☐ Disease ☐ Takes Medication at Home ☐ Needs Medication at School_____ Last Hospitalization ___ / ___ / ___ Sickle Cell Doctor's Name:
Movement Consideration	☐ Yes ☐ No	Type/Body Parts involved_____ ☐ Assistive Device Required Services provided per IEP:_____ Orthopedist: OT/PT:
Mental Health Consideration	☐ Yes ☐ No	Type:_____ ☐ Takes Medication at Home ☐ Needs Medication at School Mental Health Provider's Name:
Hearing Consideration	☐ Yes ☐ No	☐ Hearing Aids ☐ Cochlear Implant ☐ Other
Vision Consideration	☐ Yes ☐ No	☐ Glasses (reading) ☐ Glasses (distance) ☐ Contacts ☐ Other
Communication Consideration	☐ Yes ☐ No	☐ Minimally verbal ☐ Non-verbal ☐ Mutism selective/elective/total Augmentative and Alternative Communication Type:
Intellectual and Developmental Disability	☐ Yes ☐ No	☐ Intellectual Disability ☐ Autism ☐ Autism Spectrum Disorders ☐ Other I/DD Diagnosis _____
Feeding Consideration	☐ Yes ☐ No	☐ Swallowing ☐ G-Tube Feeding at School Date of last swallow study_____ Please provide documentation to the school nurse.
Elimination Consideration	☐ Yes ☐ No	☐ Diapering ☐ Catheterization at School ☐ Encopresis
Other	☐ Yes ☐ No	Describe:

*Parent/Guardian Signature _____ Date _____