

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 #

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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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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	<input type="checkbox"/> 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 _____ Antibiotic Ointment _____ Hydrocortisone Cream _____ Anti-fungal Cream
Consent	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School: _____ ADD/ADHD Doctor's Name: _____
Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Environmental/Seasonal <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School: _____
Severe Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Severe (Life threatening) to: * _____ * <input type="checkbox"/> Emergency Medication (EpiPen/Auvi-Q) <input type="checkbox"/> Does Not Have Epinephrine at School Last Date EpiPen Used ____/____/____ Allergy Doctor's Name: _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily Maintenance Medication <input type="checkbox"/> Rescue Inhaler <input type="checkbox"/> Rescue Nebulizer <input type="checkbox"/> Does Not Use/Have an Inhaler Asthma Doctor's Name: _____
Cardiac (Heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School: _____ Heart Doctor's Name: _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Blood Glucose Checks <input type="checkbox"/> Oral Medication <input type="checkbox"/> Carb Counting <input type="checkbox"/> Takes Insulin <input type="checkbox"/> Shots <input type="checkbox"/> Pump <input type="checkbox"/> Glucagon Diabetes Doctor's Name: _____
Epilepsy (Seizures)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily Medication <input type="checkbox"/> Diastat <input type="checkbox"/> Other Needs/Treatment <input type="checkbox"/> Date of Last Seizure ____/____/____ Seizure Doctor's Name: _____
Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trait <input type="checkbox"/> Disease <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School _____ Last Hospitalization ____/____/____ Sickle Cell Doctor's Name: _____
Physical Limitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ <input type="checkbox"/> Limitation <input type="checkbox"/> Assistive Device Required <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School Disability Doctor's Name: _____
Mental Health Consideration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ <input type="checkbox"/> Takes Medication at Home <input type="checkbox"/> Needs Medication at School Mental Health Provider's Name: _____
Hearing Consideration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Cochlear Implant <input type="checkbox"/> Other
Vision Consideration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Glasses (reading) <input type="checkbox"/> Glasses (distance) <input type="checkbox"/> Contacts <input type="checkbox"/> Other
Feeding Consideration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Swallowing <input type="checkbox"/> G-Tube Feeding at School
Elimination Consideration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diapering <input type="checkbox"/> Catheterization at School <input type="checkbox"/> Encopresis
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____

*Parent/Guardian Signature _____ Date _____