4. HEALTH INFORMATION / EMERGENCY CARD

Student Name: _____ DOB:_____ Age:_____ Gender: ☐ Female ☐ Male

Medication / Medical Procedures: (CCSD policy JLCD-Assisting Students with Medications)

Any medication or medical procedure to be administered by Expanded Learning requires a Doctors Order Form separate from any given to the school nurse for use during the school day. Medication must be provided by the parent in the original, sealed, properly labeled container. Doctors Order forms are available from the Expanded Learning Nurse or online at www.ccsdschools.com under the Nursing Services Section.

If you are unable to obtain medication for Expanded Learning separate from that given to the school nurse for use during the day, please contact the Expanded Learning Program Nurse at 843-209-6944 for assistance.

ADD / ADHD	☐ Yes ☐ No	☐ Takes Medication at Home ☐ Takes Medication during School Day ☐ Needs Medication after school ADD / ADHD Doctor's Name:
Allergy	☐ Yes ☐ No	☐ Environmental/Seasonal ☐ Food, allergic to:_____ ☐ Severe / Life threatening allergy to: _____ ☐ Takes Medication at Home ☐ Needs Medication at School ☐ Emergency Medication (EpiPen) Allergy Doctor: Name of Med: Date EpiPen Last Used ___/___/___
Asthma	☐ Yes ☐ No	☐ Daily Maintenance Medication at Home ☐ Rescue Inhaler ☐ Rescue Nebulizer Asthma Doctor:
Diabetes ☐ **Type 1** ☐ **Type 2**	☐ Yes ☐ No	☐ Blood Glucose Checks ☐ Oral Medication ☐ Carb Counting ☐ Insulin Injections ☐ Insulin Pump ☐ Glucagon Diabetes Doctor:
Epilepsy (Seizures)	☐ Yes ☐ No	☐ Daily Medication_____ ☐ Diastat ☐ Other Needs / Treatment _____ Date of Last Seizure ____ /____ /____ Seizure Doctor:
Mental Health Consideration	☐ Yes ☐ No	Type:_____ ☐ Takes Medication at Home ☐ Needs Medication at School Mental Health Provider: Name of Med:
Sickle Cell Anemia	☐ Yes ☐ No	☐ Trait ☐ Disease ☐ Takes Medication at Home ☐ Needs Medication at School Date of Last Hospitalization ___ / ___ / ___ Sickle Cell Doctor:
Physical Limitation	☐ Yes ☐ No	Type:_____ ☐ Limitation ☐ Assistive Device Required ☐ Takes Medication at Home ☐ Needs Medication at School Disability Doctor:
Hearing Consideration	☐ Yes ☐ No	☐ Right ☐ Left ☐ Both ☐ Hearing Aid(s) ☐ Cochlear Implant ☐ Other
Vision Consideration	☐ Yes ☐ No	☐ Glasses ☐ Contacts ☐ Other
Feeding Consideration	☐ Yes ☐ No	☐ Swallowing ☐ G-Tube Feeding at School
Elimination Consideration	☐ Yes ☐ No	☐ Diapering ☐ Catheterization at School
Individual Health Plan (IHP) on file w/ CCSD	☐ Yes ☐ No	Health Concern of the IHP:
IEP or 504 Plan on file w/ CCSD	☐ Yes ☐ No	Please describe any accommodations:
Other	☐ Yes ☐ No	Please describe:

Every school is required to have 1st Responders trained in CPR and 1st Aid. If major injury to a child occurs, the staff will immediately call for professional help (911 and the Expanded Learning Program Nurse) and will follow their instructions. Parents, designated emergency contacts, or the child's doctor will be notified as soon as possible.

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

Consent for Treatment / Release of Information

I consent for the CCSD Expanded Learning Program Nurse to provide nursing services to my child; release and exchange health and personal identification information to Medicaid for billing purposes (if applicable) which will remain confidential and NOT affect any services my child receives.

I give the Expanded Learning Program 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 at school.

Parent / Guardian Signature: _____ Date: _____