



**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](http://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.

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