Return to Nurse

# STUDENT EMERGENCY INFORMATION

Car rider/Bus Driver:_____

Student name:_____ Grade/Teacher:_____

DOB:_____ Race:___ Sex:____ SS#_____ Medicaid#_____

Address: _____City/State/Zip:_____

**Mother:**_____ Home #_____

Cell#:_____ Work #:_____ Other:_____

**Father:**_____ Home # _____

Cell#:_____ Work #:_____ Other:_____

STUDENT LIVES WITH? MOTHER FATHER BOTH PARENTS OTHER

EMERGENCY CONTACTS:

1. Name:_____ Relationship to student:_____

Home:_____ Cell: _____Other: _____

2. Name:_____ Relationship to student:_____

Home:_____ Cell: _____Other: _____

3. Name:_____ Relationship to student:_____

Home:_____ Cell: _____Other: _____

4. Name:_____ Relationship to student:_____

Home:_____ Cell: _____Other: _____

5. Name:_____ Relationship to student:_____

Home:_____ Cell: _____Other: _____

**Family Doctor:**_____

**Address:** _____

**Office Number:** _____ **Fax number:**_____

Name of previous school:_____

Phone number:_____Fax Number:)_____

DORCHESTER COUNTY SCHOOL DISTRICT 4

# CONFIDENTIAL SCHOOL HEALTH HISTORY AND CONSENT FORM

Student:_____ Race____Sex_____Grade/ Teacher_____

1. Does your child have medical problems or receive any treatment for medical problems?_____YES _____NO
   If yes, Please explain:_____
2. Does your child take any medicines everyday? _____YES _____NO
   If yes, what medication: _____
3. Has your child had surgery or been hospitalized? _____Yes _____NO
   If yes, please explain:_____
4. **Has your child ever had any of the following medical problems? Check all that apply.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Asthma | | | ADD/ADHD | | | Cancer/Tumor | |
| Diabetes | | | Epilepsy(Seizures) | | | Frequent ear infections | |
| Frequent headaches | | | Hearing loss or wears hearing aids | | | Hemophilia (Bleeding problem) | |
| Meningitis | | | Neurological (Brain or Spinal) | | | Orthopedic (Bone or Joint) | |
| Shortness of Breath | | | Skin Problems | | | Tuberculosis | |
| Urinary (Kidney or Bladder) | | | Vision (Wears Glasses or Contacts) | | | Emotional/Behavioral Problems | |
| Explain: | | | | | | | |

5. Is your **child allergic to or unable to take any medication (prescription or over the counter)?**
   Please list the name and type of reaction they have had. _____Yes _____No
   Medicine(s):_____
   Type of reaction:_____
6. **Food Allergy**? _____Yes _____No **Foods(s):**_____
   Type of reaction:_____**Verified by MD? YES NO**
7. Bee or Insect insects(s):_____Yes _____No Type of reaction?_____
8. What is your child's Doctor's name? _____Phone#_____
9. What is your child's Dentist's name? _____Phone #_____
10. What is your child's Payment source for medical care? _____Medicaid _____Health Insurance _____None

**PERMISSION FOR SERVICES**

**** I give my permission for my child to receive medication or medical treatment as deemed necessary by the school nurse or designated staff. Prescription medications may be given at the school with a Medication Permission form signed by Medical Doctor with instructions for administration, Parent's Signature giving permission to administer medication and properly labeled container from the pharmacist.**

**** In case of emergency and I cannot be reached, I would like my child transported to the nearest emergency room by Emergency Medical Services (EMS). I understand that I am responsible for all expenses associated with the emergency.**

**** I understand that information about my child will be shared on a "need to know" basis within the school. The school will also share information about my child with the Department of Health and Environmental Control (DHEC).**

****I give my permission for my child's immunizations to be added to South Carolina Immunization Registry.**

**** If applicable, by signing this form, I understand that for any period when my child is eligible for Medicaid or its related programs (Partners for Healthy Children, First Choice, PEP, and other programs that may be developed), the District may bill the Medicaid program for those services and Medicaid will pay the services performed prior to the date of this consent. By signing this form, I also give the District permission to release to the Medicaid Program any information related to these services that may be necessary for the processing or auditing of Medicaid claims.**

**Parent/Guardian Signature:_____Date:_____**