Jefferson County Schools **For School Year: 2019-2020**

CLINIC HEALTH/EMERGENCY CONTACT FORM

Student Name _____Grade _____ Homeroom _____

Age _____ Date of Birth _____ ***DRUG ALLERGIES*** _____

☐ - My child **DOES NOT** have any health problem which would affect his/her school day

☐ - My child **DOES** have health needs, health diagnosis, or need of emergency care plan for the conditions checked:

☐- ***Allergies:** ☐-**Bees** (anaphylactic reaction, not a local reaction) ☐- OTHER allergies_____

☐-**FOOD Allergies**:_____**Food Intolerance:**_____

*Is the allergy life threatening? ☐-**Yes** (requires Epi-pen & call 911) ☐-**No** (has local or mild reaction)

*Is an **Epi-pen/epinephrine** prescribed? ☐-**Yes** ☐-No (If yes, parent **must** provide Epi-pen and physicians orders)

MARK what symptoms your child has with the allergic reaction? ☐-Difficulty breathing ☐-Swelling

☐- Rash ☐- Redness/Itching at site ☐-Nausea/vomiting ☐- OTHER:_____

☐- **Asthma (diagnosed):** Is a **rescue inhaler** prescribed to be used at school? ☐Yes ☐No

☐- **Diabetes:** ☐-**Type 1** ☐-**Type 2** **Takes insulin** ☐-**Yes** ☐-**No** Other diabetes medications: _____

☐- **Seizures:** Type _____**Date of last seizure** _____ Medications taken_____

☐- **ADD/ADHD**(diagnosed) ☐-Yes ☐-No Prescribed medication taken at home:_____

Will ADHD medication be taken at school? ☐-No ☐-Yes - What: _____

☐- **Other Disorders:** ☐-Bleeding ☐-Heart ☐-Stomach ☐-Kidney ☐-Respiratory

☐- Orthopedic/Bone Joint Problem ☐-Hearing Aid ☐- Glasses ☐-Contacts

Describe Disorders/Problems: _____

☐- **Special Procedures to be performed at school:** Describe: _____

☐- **Other** medical **problem** or illness the school nurse should be aware of, include medications taken at home:

_____

Health information within the school is limited to the information necessary to serve the student's educational and health interests.

School clinics do not supply OTC medicines, including Tylenol, Tums, or cough drops.

NOTE: Per state regulations, school staff is NOT permitted to administer any medications, OTC or prescription, without signed parent consent. ALL medications, OTC and prescription must be brought to the school by the parents/guardians in the original container listing the ingredients, dose schedule and child's name affixed to the container.

PLEASE CIRCLE any medications below that **SHOULD NOT** be used when treating your child in the school clinic. Please indicate if your child has an allergic reaction to any of these medications:_____

First Aid Supplies at school include: *Anti-itch, hydrocortisone * Calamine/ Caladryl lotion
*Antibiotic Ointment *Eye Drops/Wash *Wound cleanser
*Oragel * Nose Spray (used on cotton ball for nosebleeds) *Other first aid supplies

My child is allergic to: _____

My child may be treated by the school nurse with the above listed first aid supplies (unless circled) using school protocol and package directions.

Parent / Guardian Signature X _____ **Date** _____

(FOR USE IN THE SCHOOL NURSE CLINIC)

OVER

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CLINIC HEALTH/EMERGENCY CONTACT FORM

Student Name _____Grade _____ Homeroom _____

IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT, PLEASE LIST THE PERSONS TO CONTACT IN ORDER OF DESIRED ACTION. Parents please notify school of new phone numbers.

Parent or Guardian Name and Phone Numbers

1. Name _____ Relation to student _____
   Home phone _____ Cell phone _____ Work phone_____

2. Name _____ Relation to student _____
   Home phone _____ Cell phone _____ Work phone_____

Other persons authorized to pick up child in the event of an emergency

3. Name _____ Phone: _____ Relation to student _____
4. Name _____ Phone: _____ Relation to student _____

- **I/we give permission for the school nurse to receive/release medical information to my child's physician,**
- **And in case of emergency, authorized personnel to have my child transported to the hospital by EMS if the parent/guardian or any of the above named persons cannot be reached and an emergency exists:**

Preferred Hospital _____ Physician's Name _____ Phone _____

X_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

NOTES from your School Nurse:

- **All prescription medications require a physician's orders. All medications require parent consent.**
- **Over the counter medications taken chronically, or more than two weeks, or more than recommended dosage, will require a physician's order.**
- **Parents must bring medications to the nurse's office and pick up any medications left at the school.**
- **Do not send medications with the student. Medications must be in the original package or prescription bottle.**
- **Routine or prescribed medications will be given at school ONLY if they cannot be given at home.**
- **Please contact your school office or nurse for medication forms if your child needs medication at school, including inhalers for asthma or Epi-pen for severe allergic reactions. The form can be found at *jc-schools.net*, documents, parents. The nurse may contact you about the need for a health care plan.**
- **Your child may carry an inhaler if medically authorized (indicated on Asthma Action Plan completed by physician.) and checked off by the school nurse.**
- **If your child will receive a procedure such as G-tube feed or diabetic monitoring while at school, a physicians' order must be obtained before any procedure will be performed.**
- **The school or staff shall not be held liable for injury resulting from the reasonable and prudent assistance with medication administration, or reasonable performance of health care procedures. (TCA 49.5.415)**
- **All consent forms and physicians' orders must be signed each school year.**
- **Please call the school nurse if you have any questions.**
- **Please visit jc-schools.net under Health Services department for more information.**