PLEASE KEEP A CURRENT PHONE NUMBER ON FILE IN CASE OF AN EMERGENCY

Consent for School Health Services 2018-2019

Spencer County Public Schools Health Services

School: TES **Grade**_____ **Teacher**_____

Student Information (please print):

Student Name: _____ Birthday: _____ Male/Female
Address: _____
City: _____, KY Zip _____
Parents/Guardians Names: _____
Contact Info: Home: _____ Cell: _____ Work: _____

Student Medical History

1. Significant Medical History (Chronic illness, mental health issue, recent surgery, etc.)

_____

_____

My child HAS the following life threatening condition that requires EMERGENCY TREATMENT or MEDICATIONS TO BE GIVEN AT SCHOOL.

DIABETES ____ ASTHMA _____ (Is inhaler prescribed?) _____ OTHER_____

SEIZURES ____ (Is Diastat prescribed?) _____ SEVERE ALLERGY _____(Is an Epi-pen prescribed?) ____

2. Medications ***taken at home*** on a regular basis:_____
3. **Allergies to**: Medications: _____ Foods: _____
   Bee/Wasp: _____ Latex: _____ Other: _____
4. Other pertinent medical information you think we should know: _____

_____

Student's Medical Insurance: Does your child have:

Private Insurance: Yes ☐ No ☐ **Insurance Name**: _____
Uninsured: Yes ☐ **Medical Card:** Yes ☐ No ☐

Student's Health Care Provider(s) Name: _____ Phone Number: _____
Student's Dental Provider(s) Name: _____ Phone Number: _____

Consent for School Health Services/Release for Emergency Treatment

I consent to care which may include health screenings, nursing assessments, health education/counseling, management of chronic health conditions, first aid, nursing assessments of illness and injury, and medication administration (per SCPS Medication Policies), and any other health service given to my child by a nurse working in a Spencer County Public School. I authorize the school nurse to release or obtain medical/dental information about my child to his/her healthcare or dental provider. I also understand that the information obtained for a school physical or immunization record will be released to my child's school.

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below authorizes the Spencer County Public School System and its appointed authorities to exercise their own judgment in contacting the physician indicated above and/or EMS personnel to render treatment as may be deemed necessary in an emergency. Signing this form shall release Spencer County Public Schools District and staff members from any liability of any nature in assisting your child during a medical emergency. In addition, your signature acknowledges that the parent/guardian agrees to be responsible for any and all expenses related to the medical action taken by the Spencer County School System and its appointed authorities.

SIGNATURE: _____ **DATE:** _____