Reminder: All medications must be turned into the school office.

JEFFERSON COUNTY SCHOOL SYSTEM
SCHOOL HEALTH SERVICES PERMISSION FORM 2023-24

Student's Name: _____Address_____ S.S._____

Grade____ Homeroom Teacher _____Birthdate_____ Sex: M___ F ___School _____

***** Type of Health Care:** ***Check one:*** ***Medicaid ____ PeachCare____ Insurance____ No insurance _____***

Insurance Company Name _____

Medicaid/Insurance Company Number _____

Student's Health History (Please check all that apply)

☐ ASTHMA	☐ SEIZURES/EPILEPSY	☐ CYSTIC FIBROSIS	☐ SCOLIOSIS
☐ HEART PROBLEMS	☐ KIDNEY PROBLEMS	☐ BLEEDING TENDENCIES	☐ ADD/ADHD
☐ SICKLE CELL DISEASE	☐ STOMACH PROBLEMS	☐ FREQUENT NOSE BLEEDS	☐ DEPRESSION
☐ HEADACHES	☐ SKIN DISORDERS	☐ DIABETES	☐ OTHER BEHAVIOR PROBLEMS LIST
☐ OTHER MEDICAL PROBLEMS _____			_____

Does your child require special seating in the classroom? Specify_____
Does your child wear glasses/contacts/hearing aid (please circle)?
Does your child have any condition that would limit physical activities? List_____
Please list any surgeries or hospitalizations? _____
Please list any medications your child routinely takes and times_____
_____

Child's Healthcare Provider _____Phone No._____

Child's Dentist_____Phone No._____

ALLERGIES
Is your child allergic to any medications? _____ Please List _____
Does your child have any food allergies? _____ Please List_____
Has your child had an allergic reaction to any bee/insect stings? If yes, what type of reaction occurs? _____
_____

Will your child need an Epi-pen at school? Yes____ No____ Will your child need an inhaler at school? Yes___ No ___

EMERGENCY CONTACT INFORMATION

Father/Guardian_____Phone (Home) _____Cell _____
Phone (Work) _____
Mother/Guardian_____ Phone (Home) _____Cell_____
Phone (Work) _____

IF PARENTS CANNOT BE REACHED, LIST TWO NEARBY PERSONS TO WHOM YOU GIVE PERMISSION TO ASSUME CARE OF YOUR CHILD

Name _____Relationship_____ Phone_____
Name _____Relationship_____ Phone_____

MEDICATIONS TO BE GIVEN BY SCHOOL PERSONNEL: (Whenever possible medication should be taken at home)

ONLY PRESCRIPTION MEDICINE ORDERED BY YOUR CHILD'S DOCTOR AND ACETAPMINAPEHN AND IBUPROFEN (like Tylenol and Advil) APPROVED AND PROVIDED BY PARENTS WILL BE GIVEN DURING THE SCHOOL DAY BY SCHOOL PERSONNEL.

NO MEDICATIONS WILL BE ADMINISTERED WITHOUT THIS SIGNED PERMISSION FORM FROM THE PARENT
I hereby grant the school permission to give necessary minor treatment and/or non-prescription medications to my child. I authorize the school to discuss and share appropriate and necessary information with other health agencies and my child's primary care physician for the purpose of follow-up as needed. I also grant the school permission to conduct routine health screening (vision, hearing, dental, etc.) for my child and notify me of any abnormal results.

In case of serious illness/injury, the school will provide first aid and parents will be contacted. If neither the parent nor designee can be reached and the situation is very serious, the student will be transported to the nearest emergency room and/or EMS will be contacted for immediate transportation to the emergency room. **Fees for transportation and medical services will be the responsibility of the parent or guardian.**

____ I agree for my child to receive school health services. I will notify the school of any change in my child's health status.

____ I **DO NOT** want my child to receive school health services.

PARENT/GUARDIAN SIGNATURE: _____ DATE _____

July 2023