SCOTT COUNTY SCHOOLS

Student Health Information Sheet 20__- 20__

Scott County Schools Health Services Division 2168 Frankfort Pike Georgetown, KY 40324

Student name: _____ Date of birth: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

Student's Health Care Provider: _____

Telephone: _____

Student Medical History

1. Significant Medical History/Medical Diagnosis:
   _____
2. Medication Allergies: _____
   Food allergies: _____
3. Medications Taken Daily: _____
4. Prescription Medication to be Given at School (you must complete the Drug Consent Form before administration at school): _____
   _____
5. Does your student have any of the following **Life-Threatening** conditions that may require **EMERGENCY** treatment or medications to be administered at school? (additional paperwork will be required including medication consent form, emergency action plan, and individual health plan)

☐ Diabetes (glucagon) ☐ Asthma (inhaler) ☐ Seizures (Diastat) ☐ Severe Allergy (Epi-Pen)

Insurance information

Health Insurance Provider: _____ Employer: _____

Policy Number: _____ Group Number: _____

Emergency Treatment Authorization

I, the undersigned, authorize Scott County Public Schools officials to contact the person mentioned above and authorize the named EMS physician or staff to provide treatment as deemed necessary in an emergency, for the health of the named child.

In the event that the parent/guardian, physician, or other persons named on this form cannot be contacted, Scott County Public Schools officials are authorized to take any action deemed necessary, in their opinion, for the health of that child.

I will not hold the school district financially responsible for that child's emergency care and/or transportation.

Signing this form will free Scott County Public Schools and staff members from any responsibility of any kind for assistance during a media emergency.

Parent/guardian signature: _____ Date: _____

PLEASE COMPLETE THE OTHERSIDE

NON-PRESCRIPTION TOPICAL MEDICATION PERMISSION FORM

Student Name	Teacher	Date of birth

As the parent/ legal guardian of the above-named student, I authorize the school nurse or designee to give my child non-prescription, over-the-counter (OTC) topical medications during the school year in accordance with the Scott County School Medication policy as the need arises. ***NO VERBAL PERMISSION WILL BE ACCEPTED***

By initialing the below listed medications, I am certifying that my child has previously used or taken this medication at least ONE time.

Yes	No		Yes	No	
☐	☐	Hydrocortisone cream	☐	☐	Saline Drops (eyes)
☐	☐	Topical Diphenhydramine (Benadryl)	☐	☐	Orajel / Anbesol
☐	☐	Calamine Lotion	☐	☐	Hydrogen Peroxide or Wound Spray
☐	☐	Antibiotic Ointment (Bacitracin, Neomycin Sulfate, Polymyxin Sulfate)	☐	☐	Burn Cream (Benzalkonium, Lidocaine)
☐	☐	Sunscreen	☐	☐	Aloe Vera Gel

- ♦ The nurse/designee will use professional judgement to determine whether to administer any medication listed above that has been initialed and signed by parent/guardian.
  - The nurse has a right to refuse to administer any medication she believes is not in the best interest of the student due to dosage, side effects or any other concerns.
- ♦ The above listed medications MAY BE PROVIDED by the school your student attends and if so, will be age appropriate, and will be administered according to the manufacturer's label.
- ♦ Should a student be noticed to request OTC topical medications more frequently than normal, the parent/guardian will be notified so further investigation or action can be implemented.
- ♦ Permission for OTC topical medications will need to be renewed each school year.
- ♦ Parent/Legal guardian may WITHDRAW signed permission with a written request at any time.

Refer to medication policy for full disclosure and instructions

MEDICATION HISTORY:

Is your student allergic to any topical medications? ☐ YES ☐ NO

If YES, please list medication and reaction: _____

_____

I hereby give my permission for the above initialed non-prescription medications to be administered to my child as needed by the school nurse or designee. I certify my child has taken/used this medication previously with no known adverse reactions. I will NOT hold the school staff responsible for any undesired reaction that may occur from the administration of said medications.

Parent/Legal Guardian Signature_____Date:_____

_____

School Nurse/Date

PLEASE COMPLETE OTHER SIDE