MT. VERNON TOWNSHIP HIGH SCHOOL

11101 Wells Bypass Rd.

Mt. Vernon, IL 62864

Sophomores

Nurse's Office Requirements

- Emergency Sheet (See attached as it is not the same form as online registration)
- Medication form (Parent and doctor signature required) (if applicable)
- Medicaid Access form (if applicable)

Bring required documents as listed above to registration in August as they are mandated by the state.

Forms for medication can be found at:

http://www.mvths.org/ Parent Resources/Nurses Office

STUDENT EMERGENCY INFORMATION

FOR THE NURSE'S OFFICE B110

Last Name_____ **First**_____ **M**_____

Student Date of Birth_____ **Student ID#**_____

Address:_____

Guardian Name_____ **Phone**_____

Allergies:_____

Health Concerns:_____

_____

Medication student is currently takes:_____

_____

Name of medication that will be taken during school hours? (must have medication form on file in the nurse's office with doctor and parent/guardian signature, this includes orders for over-the-counter medication)_____

_____

Doctor:_____ **phone**_____

Hospital preference: _____

EMERGENCY CONTACTS: (if a parent cannot be reached I hereby authorize the following people to be called or pick up my student in case of illness, emergency or other reason.

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

Name_____ **Relationship**_____ **Phone**_____

I hereby release the school nurse or employees of Mt. Vernon Township High School District #201 to contact my agency or facility maintaining medical records regarding my child for the purpose of providing information (immunization records, school health examinations, medication, and/or treatments) medically necessary for my student's wellbeing at school. In the event a parent cannot be contacted, this release gives Mt. Vernon Township High School permission to seek medical attention for the student in case of emergency. I agree to assume responsibility and expense, including transportation cost, incurred providing this medical care.

Signature of Guardian _____ *Date*_____

MT. VERNON TOWNSHIP HIGH SCHOOL

Established: 1905 - Over 100 Years of Educational Success

11101 North Wells Bypass
Mt. Vernon, IL 62864
618-246-1830
Nurse's Office

Mt. Vernon Township High School
Dist. 201
Health Services/ Nurse's Office

Dear Parent/Guardian:

Illinois Department of Human Services enables all schools in Illinois to receive funds through the Medicaid Program. Some of the services provided are: hearing and vision screening, speech evaluation, dental, and other medical services.

If your student is eligible for either these services, please provide us with his/her recipient number, so that we can utilize this statewide program. Please fill in the recipient number that appears next to your child's name on your Med plan card, (this is the nine digits.)

Student's Name:_____

Student's Address:_____

Student's Sex:_____Student's Date of Birth:_____Student's ID_____

Student's Recipient/Medicaid Number:_____

Student's Social Security Number:_____

Date:_____

Parent/Guardian Signature:_____

This consent form will be valid as long as your child is eligible for Medicaid program, or until the parent/guardian withdraws their consent in writing.

Please complete the above information and return to the Nurse's Office. If you have any questions, please call 246-1830 or 246-1832.

Mt. Vernon Township High School
Authorization and Permission for Administration of Medication

Student Name _____ Birth Date _____ Class ____
(Last) (First) (Initial)

Medication Allergies _____

Parental Authorization:

I, the parent/guardian of _____, a student at Mt. Vernon Township High School District #201, hereby acknowledge that I am primarily responsible for administering medication to my child. However, during school hours when I am unable to administer or in the event of an emergency, I hereby authorize Mt. Vernon Township High School District #201 and its employees, on my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the school district), the following named prescription medication, non-prescription medication or over-the-counter medication following manufacturer's guidelines or prescription medication as ordered by the physician.

I acknowledge that prescription medications, non-prescription medication or over-the-counter medication will be administered by or under the supervision of the certified school nurse, parent, or administrative staff, and specifically consent to such practices. I further acknowledge and agree that, when the medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees, and School Board/Administration arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and School Board/Administration, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

I have read, understand and agree to the regulations concerning administration of medication at school. I agree to the release of health information between school and physician.

Parent/Guardian Signature _____ ***Phone*** _____

Physician Authorization: **Tylenol 500mg. 1 tab po every 4-6 hrs. PRN**

_____ or **Ibuprofen 200mg. 1 or 2 tabs. po q 6-8 hrs. PRN**

Diagnosis: General aches and pains _____

Intended effect of this medication: Pain relief and to allow student to remain at school.

Expected side effects, if any: _____

Other medications student is taking: _____

Administration instructions: _____

_____	_____	_____	_____
Prescriber's Name	***Prescriber Signature***	**Date**	**Prescriber's Phone #**

Please return or FAX to MVTHS Nurse Office at 618-246-1767

Mt. Vernon Township High School

Authorization and Permission for Administration of Medication

Return or **FAX to the Nurse Office at 618-246-1767**

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(Last) (First) (Initial)

Medication **Allergies** _____

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I have read, understand and agree to the regulations concerning administration of medication at school. I agree to the release of health information between school and physician.

Parent/Guardian Signature _____ ***Phone*** _____

Physician Authorization:

_____	_____	_____
Medication to be given	**Dosage/Route**	**Time to be administered**

Administration instructions: _____

Diagnosis requiring medication: _____

Intended effect of this medication: _____

Expected side effects: _____

Other medications student is taking: _____

_____	_____	_____	_____
Prescriber's Name	***Prescriber Signature***	**Date**	**Prescriber's Phone #**