2019-2020 BRDHD CONSENT FOR SCHOOL HEALTH SERVICES

PLEASE FILL OUT ALL INFORMATION SITE #:_____

HOMEROOM TEACHER:_____GRADE:_____ LANGUAGE(S) SPOKEN AT HOME_____

CHILD'S LEGAL NAME_____ BIRTHDATE:_____ RACE:_____ ☐MALE ☐FEMALE

CHILD'S SOCIAL SECURITY NUMBER:_____ *(USED FOR BRDHD BILLING ONLY)*

KY MEDICAID ID NUMBER:_____ IS YOUR CHILD EXPOSED TO TOBACCO? ☐YES ☐NO

ADDRESS:_____CITY/ STATE/ ZIP _____

CHILD'S TRANSPORTATION: ☐BUS RIDER ☐ CAR RIDER ☐ WALKER ☐ ATTENDS AFTER SCHOOL PROGRAM AT SCHOOL

PARENT/ GUARDIAN NAME:_____ RELATIONSHIP TO CHILD:_____

HOME PHONE #:_____ CELL PHONE #_____ WORK PHONE #_____

PARENT/ GUARDIAN NAME:_____ RELATIONSHIP TO CHILD:_____

HOME PHONE #:_____ CELL PHONE #_____ WORK PHONE #_____

EMERGENCY CONTACT (other than parent):_____ RELATIONSHIP TO CHILD:_____

HOME PHONE #_____ CELL PHONE #_____ WORK PHONE#_____

☐ **MEDICATION ALLERGIES: _____**

☐**RED DYE ALLERGY** ☐ **LATEX ALLERGY** ☐ **CANNOT SWALLOW PILLS**

PLEASE CHECK which of the following medications you WILL ALLOW your child to be given by nurse. Doses will be given according to the child's age and weight according to BRDHD's medical director's order. BRDHD medications are not dye-free and those with an * contain red dye and will not be administered to anyone stating they have a red dye allergy.**

☐Acetaminophen (Tylenol)*** ☐Ibuprofen (Advil/ Motrin) ☐Orajel*** ☐Hydrocortisone

☐Antacid (Tums or liquid) ***pink tablets*** ☐Anti-Nausea Medicine (Emetrol)*** ☐Claritin (Loratidine – for allergies) ☐Bacitracin ☐Calamine

☐Sun Screen ☐Aloe Vera (for burns) ☐Sore Throat Lozenge/ Cough Drop ***cherry flavored*** ☐Cough Syrup***

Any medications checked will be administered, as per your consent, without contact from the school nurse. A copy of the nurse's notes will be sent home to the parent/ guardian stating what medications were given, dosage, and time. It is the child's responsibility to get this copy to the parent/ guardian. The school nurses cannot take consent to give medications over the phone.

IF THIS INFORMATION SHOULD CHANGE, PLEASE NOTIFY THE SCHOOL NURSE IMMEDIATELY.

CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS (Valid for school year listed above)

I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include screenings such as vision, hearing, and dental screenings, physical exam, treatment, first aid, over the counter medication as indicated above, and any other health service given to my child by staff or agents of the Barren River District Health Department. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I like-wise release the staff from any liability related to the administering of the above medications to my child as long as the responsibility is discharged according to the above instructions. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a healthcare worker is exposed to his/her blood, body fluids or tissue. I authorize the school health clinic to release and receive medical information about my child, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share pertinent medical information (history of allergies or significant medical history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I also give permission for school health clinic staff to view my child's Individual Education Plan (IEP). Further, I understand that information obtained during school physicals and immunization information will be released to my child's school. I request that payment of authorized medical insurance benefits be made to Barren River District Health Department on my behalf, for services my child receives. I also authorize the local health department to release medical information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Barren River District Health Department's Privacy Notice.

I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

_____ _____ _____

(Signature of Custodial Parent/Guardian) (Printed Name of Custodial Parent/Guardian) (Date Signed)

******IT IS MANDATORY TO COMPLETE BACKSIDE OF CONSENT******

2019-2020

CF-1 BRDHD 05/2019

2019-2020