LINCOLN COUNTY BOARD OF EDUCATION

POST OFFICE BOX 265
STANFORD, KENTUCKY 40484
(606) 365-2124

Dear Parent/Guardian,

Attached are copies of the forms required to provide health services in the schools. Both the medical emergency information form and the consent for health services forms should be returned to the school nurse as soon as possible. Also attached are two medication consent forms. The consent for non prescription medications should be returned if you would like your child to be able to receive medications from the school nurse. The permission form for prescribed or over the counter medication should be returned if your son/daughter is on a daily medication you need given at school or if you have over the counter medication you wish to send to school for your child.

These forms are also available on the district website at http://www.lincoln.kyschools.us/schoolhealth/Health%20Services.htm under the Coordinated School Health tab.

If you have any questions please contact the nurse at your school or the school health office at 365-7287.

Please Return to School

Consent for School Health Services

Lincoln County Health Department
School Health Office

Child/Student Information

Teacher_____ School_____ Grade_____

Last Name_____ First Name_____ MI ____
(Please give child's complete legal name)

Child's Social Security #_____ **Birth Date**_____

Race_____ Male / Female How many people live in the home?_____

Street Address_____ City_____ Zip_____

Mother _____ Hm Ph_____ Wk Ph_____ Cell Ph_____

Father _____ Hm Ph_____ Wk Ph_____ Cell Ph_____

Legal Guardian _____ Hm Ph_____ Wk Ph_____ Cell Ph_____

Emergency Contact Person **OTHER** than guardian or parent_____

Home Phone_____ Cell Phone_____ Work Phone _____

Is your child **eligible** for free or reduced lunch? Yes / No / Don't know

Last School Attended_____

Medical Insurance

Does your child have a KY Medicaid Card Yes / No Number_____
Does your child have a KCHIP Card Yes / No Number_____
Does your child have any other medical insurance? Yes / No
Family Physician_____ Phone_____

Consent for Health Services/Assignment of Benefits

I consent to care which may include screening, exams, assessments, lab tests, treatment, first aid, and any other health service given to me/my child by staff or agents of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to release medical information about my child to his/her primary care provider as well as obtain medical information regarding care at school. I also understand that the information obtained for the school physical, including immunization information, will be put in my child's school cumulative record. If my child has Medicaid or KCHIP, I authorize the school clinic to release this information to Medicaid/KCHIP so that the Medicaid/KCHIP can be billed for visits to the school clinic. I understand that I will not be billed for any services that my child receives at the school clinic. I also understand by signing this consent, I acknowledge that I have received a copy of the Lincoln County Health Department's Privacy Notice.

X_____

(Signature of parent /legal guardian / emancipated student) **(Date signed)**

Medical Emergency Information Form

Full Name of Student: _____ Date of Birth: _____

Address: _____ Phone: _____

Homeroom Teacher: _____ Grade: _____ Legal Guardian: _____

TO THE PARENT(S)/GUARDIAN: The following information is required so that school personnel may serve your child in case of an accident or sudden illness.

Please complete in ink and press firmly so that all copies are legible.

Student's Doctor: _____

Address: _____ Phone: _____

Student's Dentist: _____

Address: _____ Phone: _____

Does your child have a medical history of heart disease, diabetes, TB, nervous disorder, ear infections, seizure activity, asthma, hemophilia, blood transfusions, etc.? Any surgery? If *yes*, please indicate below:

_____

_____

Does your child have any known allergies such as to medications, bee stings, etc.? Please explain and list the type of reaction such as *localized swelling, anaphylactic shock, respiratory distress.*

_____

_____

Is your child on any routine medication? ☐ Yes ☐ No If *yes*, list the medication(s) and for what condition it is taken: _____

_____

If child is on any routine medication, will medication be administered at school? ☐ Yes ☐ No

If a medical emergency requires immediate medical care due to an accident or sudden illness, school personnel will attempt to contact the legal guardian(s) or other contacts listed on this form. In the case that the legal guardian cannot be contacted, please sign below to indicate that you understand that the student would be transported by emergency medical services for emergency treatment to the NEAREST FACILITY. The legal guardian would be responsible for transportation and medical treatment fees.

REQUIRES PARENT/LEGAL GUARDIAN SIGNATURE:

X Signature: _____ Date: _____

Review/Revised: 6/5/08

Consent for Non-Emergency First Aid, & Non-Prescription Medications Kept at School

STUDENT NAME: _____ BIRTHDATE: _____ AGE: _____ GRADE: ___

KNOWN DRUG ALLERGIES: _____

OTHER ALLERGIES: _____

Many times during the school year, a student may suffer from a minor pain/discomfort, such as a headache, toothache, stomachache, or minor skin irritation. With your consent, designated medication distribution personnel may provide your child with the following non-prescription, first aid or comfort measures, if needed.

All over-the-counter medications are given according to the age/wt appropriate dosage & per package directions.

Acetaminophen	Tylenol or generic	Yes_____	No_____
Antihistamine	Benadryl or generic	Yes_____	No_____
Anti-Infection	Neosporin or generic	Yes_____	No_____
Anti-itch	Caladryl, Cortisone-5 or generic	Yes_____	No_____
Antacids	Tums, Mylanta or generic	Yes_____	No_____
Chapped Lip Relief	Blistex or Petroleum Jelly	Yes_____	No_____
Cough Drops/Syrup/Spray	Robitussin, Chloraseptic or generic	Yes_____	No_____
Decongestant	Dimetapp, Sudafed or generic	Yes_____	No_____
Eye Wash	Saline or Commercially prepared	Yes_____	No_____
Ibuprofen	Motrin, Advil or generic	Yes_____	No_____
Insect Bite/Sting Relief	Sting Relief or Sting Kill	Yes_____	No_____
Gum Pain Relief	Orajel, Anbesol or generic	Yes_____	No_____
Sunburn Relief	Solarcaine, Aloe, Medi-Quik	Yes_____	No_____
Wound Cleaning	Antiseptic Wash or Peroxide	Yes_____	No_____

FOR HIGH SCHOOL ONLY:

Midol	Midol, Tylenol Women or generic	Yes_____	No_____
Naproxen	Aleve or generic	Yes_____	No_____

I understand that ***non-prescription medications*** can only be given for **three (3) days** without a physician's order. I hereby agree to release and hold the staff free and harmless for any claims, demands, or suits for damages from any injury or complication resulting from treatment approved by me on this consent form, unless such is the result of negligence or misconduct on behalf of the school or its employees. I HAVE READ THIS CONSENT FORM AND UNDERSTAND ALL ITS TERMS. I EXECUTE IT VOLUNTARILY AND WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.

X _____ _____

Signature of Parent/Guardian *Date consent given*

If your child becomes too ill to remain at school, WE MUST BE ABLE TO REACH YOU OR AN EMERGENCY CONTACT to pick them up.

Name (Please Print)	Phone #(s)	Social Security Number
_____	_____	_____
_____	_____	_____

The Parent/Guardian may rescind this consent at any time.

Date received by School: _____ Person receiving: _____

Review/Revised:8/9/2007

Lincoln County Health Department
School Health Office
NOTICE OF PRIVACY PRACTICS
Effective Date: 04/14/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE
You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your Protected Health Information (PHI) and your privacy rights.

WHAT IS THIS NOTICE
This Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
This notice tells you:
- How this Health Department and its contracted business partners may use and give out your PHI to carry out treatment, services, payment or health care operations and for the purposes permitted or required by law.
- What YOUR rights are regarding the access and control of you health information.
- How this Health Department protects your health information.

OUR PRIVACY PROMISE TO YOU
Your health information is personal. This Health Department is legally required by law to protect the privacy of your Protected Health Information (PHI). It does so in all aspects of its business. This Health Department has policies about the privacy of your Protected Health Information (PHI). ***These policies comply with State and Federal laws.*** This Health Department uses and gives out your health information only where required by law or where necessary for business.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION
Each time you receive a service from a health department, hospital, physician, or other healthcare provider, a record of your visit is made. This record contains information about you, including information that may identify you and that relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you. For example, this information, often referred to as your health or medical record, serves as a:
- Basis for planning your care.
- Means of communication among the many health professionals who are involved in your care.
- Means by which you or a third-party payer (insurance provider) can check that services billed were actually provided.

Your health record contains PHI. State and Federal law protects this information. Understanding how we may use and share your health information helps you to:
- Understand the need to make sure it is correct,
- Better understand who, what, when, where and why others may access your health information, and,
- Make more informed decisions when authorizing sharing with others

YOUR HEALTH INFORMATION RIGHTS
Although your health record is the physical property of the health department that compiled it, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

- Request a restriction on certain uses and sharing of your information. This means you may ask us not to use or share any part of your PHI for purposes of treatment, payment or healthcare operation. You may also ask that this information not be disclosed to family members or friends who may be involved in your care. This health department is not required to honor your request.
- Request that we send you confidential communications by alternative means or at alternative locations.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and obtain a copy of your health record. We may charge a fee for costs of copying.
- Request the portions of your medical record regarding PHI be changed.
- Amend your medical information.
- Obtain a listing of certain health information we were authorized to share for purposes other than treatment, payment or health care operations after April 14, 2003.
- Take back your authorization to use or share health information except to the extent that action has already been taken except as public health law allows.
- Right to an accounting of disclosures. You may request that we provide you with an accounting of the disclosures we have made of your PHI. This right applies to disclosures made for purposes other than treatment, payment, or health care operations. The disclosure must have been made after April 14, 2003 and no more than 6 years from the date of request. This right excludes disclosures made to you, to family members or friends involved in you care, or for notification.

HEALTH DEPARTMENT RESPONSIBILITIES
This health department is required to:
- Maintain the privacy of your health information.
- Provide you with this notice.
- Abide by the terms of the notice currently in effect.
- Notify you if we are unable to agree to a restriction/amendment you request.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

The Health Department reserves the right to change our practices and to make the new policies effective for all PHI we maintain at the time. The effective date of the change is at the top of the first page and at the bottom of the last page. Should our information practices change, this information will be posted in this health department and a copy will be provided at your next visit.

We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR HEALTH OPERATIONS
These examples are do not include all possibilities.

Required uses and disclosures
By law, we must disclose you health information to you unless it has been determined by a competent medical authority that it would be harmful to you.

We will use your health information for services, and treatment.
For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of services that should work best for you. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions.

We will use your health information for payment.
For example: A bill may be sent to a third-party payer, such as an insurance provider. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
We may use/disclose your PHI in fulfilling the health department responsibilities. We may use your information to determine your eligibility for other services.
For example: Staff may look at your record when reviewing the quality of services you are provided. Members of the risk or quality improvement team may use information in your health record to assess the quality and effectiveness of the healthcare and services we provide. We may use/disclose medical information to contact you as a reminder that you have an appointment. We may call you by name in the waiting room when we are ready to see you.

We may use/disclose PHI to tell you about or recommend treatment or other health-related benefits and services that may be of interest to you.

Business Associates: There are some services provided in our health department through contracts with business associates. Whenever an arrangement between our office and a business associate involves the use or sharing of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. Information shall be made available on a need-to-know basis for these activities associated with compliance with regulatory agencies.

USES AND SHARING OF INFORMATION SPECIFICALLY AUTHORIZED BY YOU:
Use and disclosures of your PHI beyond treatment, payment and operations, will be made only with your written authorization, unless otherwise permitted or required by law described below.

Others involved in your healthcare:
We may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Unless you object, we may contact you as a reminder that you have an appointment.

OTHER PERMITTED AND REQUIRED USES AND SHARING THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT:

We may use and share your PHI. It will be limited to the requirements of the law including but not limited to the following instances:

Required by Law:
We may use/disclose your PHI if law or regulation requires the use/disclosure.

Public Health Emergencies:
We may use or share your PHI in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable. Finally, we may use or share your PHI with an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

- Under KRS 214.020 When there is a probability that any infectious or contagious disease will invade this state, we may take such action and adopt and enforce such rules and regulations as we deem efficient in preventing the introduction or spread of such infectious or contagious disease or diseases within this state, up to and including a quarantine and isolation.
- Under KRS 214.010 Every physician shall report all diseases designated by regulation of the Cabinet for Health Services as reportable which are under his special treatment to the local board of health of his county, and every head of a family shall report any of said diseases, when known by him to exist in his family, to the local board or to some other board member.

Public Health:
As required by law, we may disclose your PHI to state and federal public health, or legal authorities charged with preventing or controlling disease, injury, or disability. We may share your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of getting or spreading the disease or condition. Information will be released to avert a serious threat to health or safety. Any disclosure, however, would only be to someone authorized to receive that information pursuant to law.

- Under KRS 194A.060, all records and reports of CHS (or CHR) which directly or indirectly identify a patient or client, or former patient or client, of the Cabinet, are confidential.
- Under KRS 214.420, all information in the possession of local health departments or CHS concerning persons tested for, having, or suspected of having sexually transmitted diseases, or identified in an epidemiologic investigation for sexually transmitted diseases, is strictly confidential. A general authorization for the release of medical or other information is not sufficient to authorize release of this information. Breach of this confidentiality is considered a violation under KRS 214.990.
- Under KRS 214.181, no test results relating to human immunodeficiency virus are to be disclosed to unauthorized persons.
- Under KRS 222.271, treatment records of alcohol and drug abuse patients are confidential.
- Under KRS 216.2927, raw data used by the Kentucky Health Policy Board are confidential. This includes data, data summaries, correspondence, or notes that could be used to identify an individual patient, member of the general public, or employee of a health care provider.
- Under KRS 202A.091, court records relating to hospitalization of the mentally ill are confidential. Violation of the confidentiality of these records is a Class B misdemeanor under KRS 202A.991.
- Under KRS 202B.180, court records relating to mental retardation admissions are confidential. Violation of the confidentiality of these records is a Class A misdemeanor under KRS 202B.990.
- Under KRS 210.235, all records which directly or indirectly identify any patient, former patient, or person whose hospitalization has been sought, are confidential.
- Under KRS 211.902, the names of individuals are not to be disclosed in connection with lead poisoning records, except as determined necessary by the Cabinet Secretary.
- Under KRS 211.670, lists maintained by hospitals, and all information collected and analyzed, relating to the Kentucky birth surveillance registry (concerning birth defects, stillbirths, and high risk conditions) are to be held confidential as to the identity of the patient. Violation of this confidentiality is a Class A misdemeanor under KRS 211.991.
- Under KRS 213.131, unauthorized disclosure or inspection of vital records is unlawful. Violation of the confidentiality laws for vital statistics is a Class B misdemeanor under KRS 213.991

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Abuse, Neglect, Exploitation:
We may disclose your relevant PHI to the Cabinet for Families and Children or other appropriate government authority that is authorized by law to receive reports of abuse, neglect and exploitation. In addition, we may disclose your relevant PHI if we believe that you have been a victim of abuse, neglect, exploitation or domestic violence to the governmental agency authorized to receive such information.

Health Oversight:
We may share your PHI with health oversight agencies such as federal and state Departments of Health and Human Services, Medicare/Medicaid Peer Review Organizations, the United States Department of Agriculture (USDA) or the Center for Disease Control (CDC) for activities such as audits, investigations and inspections or compliance with civil rights laws.

Judicial and administrative proceedings:
We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information (See Cabinet for Health Services Administrative Order, CHS 01-08, August 28, 2001) (Institutional Review Board for the Protection of Human Subjects).

Coroners, Funeral Directors, and Organ Donation:
We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose relevant PHI to a funeral director, as authorized by law in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Law Enforcement/Legal Proceedings:
We may disclose health records for law enforcement purposes as required by law or in response to a valid subpoena, discovery request or other lawful process. These law enforcement purposes include (1) legal processes; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; (5) in the event that a crime occurs on the premises of the Department, including its facilities; and (6) medical emergency and it is likely that a crime has occurred. Also we may disclose information to government agencies.

Correctional Institution:
Should you be an inmate of a correctional institution, we may disclose to the Corrections Cabinet health information necessary for your health and the health and safety of other individuals.

Military, national security:
If you are involved with the military, national security or intelligence activities, we may release your health information to the proper authorities so they may carry out their duties under the law.

Workers Compensation:
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Information that is not Personally Identifiable:
We may disclose information about you in a way that does not personally identify you or reveal who you are.

Right to Paper Copy of Notice
You have the right to receive a paper copy of this Notice at any time. To receive a paper copy, send a written request to the **Health Department** ***address below.***

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

The Health Department has the right to change this Privacy Notice at any time. If we do make a change, we will revise this Notice and promptly distribute it to all clients. The Health Department is required by law to comply with the current version of this Notice until a new version has been distributed.

WHERE DO YOU SEND QUESTIONS OR REQUESTS

To submit questions about your privacy rights, contact the Health Department at:
Lincoln County Health Department
44 Health Way
Stanford, Kentucky 40484
Or, you may call the Department Privacy Officer by dialing (606) 365-3106

COMPLAINTS

If you believe your privacy rights have been violated and wish to make a complaint, you may file a complaint by calling or writing:

- The Health Department Privacy Officer at the ***number and address above.***
- The Secretary of Health and Human Services at:
  Secretary of Health and Human Services, Room 615F
  200 Independence Ave, SW

Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Age:** _____ **Date of Birth:** _____

Grade: _____ **Homeroom/Classroom:** _____

Name of Medication: _____

☐ Prescription medication ☐ Over-the-counter medication provided by parent/guardian

Dose and Time: _____

Reason for Medicine: _____

Starting Date:

☐ Date form received ☐ Other (*Specify.*) _____

Stopping Date:

☐ For short-term infection/sickness ☐ End of school year ☐ Other date/duration: _____

Restrictions and/or side effects: _____

Must student carry this medication on his/her person? ☐ No ☐ Yes (If *yes*, special arrangements must be made. School staff will contact you.)

Student has been instructed in self-administering the medication: ☐No ☐Yes

Please indicate additional information: ☐ On the back of this form ☐ As an attachment

_____ _____

Parent/Guardian's Signature ***Date***

Physician's Name: _____

Address: _____

Phone #: _____ **Fax #:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for _____ *to receive the above medication at school according to*
Student's Name

standard school policy and expressly hold harmless and release the Lincoln County School System or its employees and agents concerning any injuries or reactions from liability resulting from giving the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with enough medication to let the doctor's orders be followed.

_____ _____ _____

Signature ***Date*** ***Relationship***

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the authorization to give medication and student medication.

_____ _____

Administrator/Designee's Signature ***Date***

Review/Revised: 8/15/05