Med Center Health

CONSENT FOR MEDICATIONS AND PROCEDURES

Student's Name ______________________________ DOB: ________________

School: ______________________________ Date Form By the School: __________

Primary Care Provider: ________________________ PCP Phone: ____________________

I give permission for ________________________ to receive the medications and or procedures
Student's Name
below at school according to standard school policy and/or physician orders and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries from administration of the listed medications or procedures unless such is the result of negligence or misconduct on behalf of the school or its employees.

I understand that all medications are to be provided to the school and/or school nurse in the original container per Student Handbook policy on medications. A provider order will be needed in order for a student to be given medication or procedure at school.

Parent/Legal Guardian Signature: ______________________________ Relationship: __________________

Parent/Legal Guardian Printed Name: ___________________________ Date: __________________

Home Phone: __________________________ Work Phone: __________________________

Emergency Phone: ________________________

<u>TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER**</u>**

What Medications does this child need for school ?:

______ Auvi-Q ______ Benadryl ______ EpiPen ______ EpiPen Jr.
______ Diastat ______ Inhaler ______ Insulin Pen ______ Insulin Pump
______ Glucagon ______ Insulin Syringe/Vial ______ Twinject ______ Nebulizer Medication
______ Vagal Nerve Stimulator/Magnet ______ Other ________________________

Reason for medication: ____

Form of medication/treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ Nebulizer ☐ Other ____________

Instructions (Schedule and dose to be given at school): ____

Start: ☐ Date form received ☐ Other, as specified: ______________________________

Stop: ☐ End of school year ☐ Other, date/duration: ______________________________

☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restrictions ☐ Yes, please describe: __________________

____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: ____________________________

____

Student has been trained and may carry and administer own emergency medication ☐ Yes ☐ No

**** Does this child require medications for sports, afterschool programs, and/or field trips per MD? __ Yes __No**

What procedures will this child need for school?:

______ Catheterization ______ Tube Feeding ______ Seizure Monitoring
______ Diabetic Care ______ Ostomy Care ______ Respiratory Monitoring
______ Toilet Monitoring ______ Dressing Changes ______ Other: ________________

Physician's Signature ______________________________________ Date ________ Time ________

Physician's Name ____________________________________ Phone ____________________

Address ____ Fax____________________

Med Center Health

School Health Services Consent

HOMEROOM TEACHER:_____________________ GRADE:_______ LANGUAGE(S) SPOKEN AT HOME:_____________________________

CHILD'S LEGAL NAME________________________ BIRTHDATE:________________ RACE:_________ MALE___ FEMALE___

CHILD'S SOCIAL SECURITY NUMBER:____________________________________

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 medical director's order. 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 Cream _____ Calamine Lotion

_____ Antacid*** _____Anti-Nausea Medicine *** _____ Antihistamine for allergy symptoms _____ Bacitracin Ointment

_____ Sun Screen _____Aloe Vera (for burns) _____ Sore Throat Lozenge/ Cough Drop*** _____ 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 exams, treatment, first aid, over the counter medication as indicated above, and any other health service given to my child by Med Center Health. 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 health care 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 Act of 1996 (HIPPA), 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 authorize Med Center Health 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 Med Center Health'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)

Med Center Health

Student Health Questionnaire

Student's Name ______________________________ DOB: ________________

School: ______________________________ Date Form Received By the School: ________

Primary Care Provider: ______________________________ PCP Phone: ____________________

Please list any medications (Over-the-counter and prescription), vitamins, herbs, supplements currently taking or any oils currently using: ____

____

____

Please check if the child has a confirmed medical history of any of the following:

CARDIOVASCULAR
____ Heart Murmur/Defect
____ High Blood Pressure
____ Pacemaker
____ Life Pack/LVAD Heart Pump

DEVELOPMENTAL/PSYCH
____ ADHD/ADD
____ Developmental Delays
____ Down Syndrome
____ Autism
____ Mood Problems/Depression

ENDOCRINE
____ Heart Murmur/Defect

DIGESTIVE/RECTAL/URINARY
____ Frequent Stomach aches
____ Acid Reflux
____ Wears Diapers
____ Incontinence of Stool
____ Recurrent Urinary Tract Infections

DIGESTIVE/RECTAL/URINARY
____ Inability to void w/o Catheterization
____ Kidney Disease
____ Incontinence of Urine
____ Ostomy
____ Urinary Frequency
____ Lactose Intolerant
____ Constipation Requiring MD Visits
____ Inability to eat w/o Tube Feeding

HEAD/EYE/EAR/NOSE/THROAT
____ Dental Decay/Problems
____ Frequent Sinus Infections
____ Frequent Ear Infections
____ Hearing Loss or Difficulty
____ Vision Loss or Difficulty
____ Migraine Headaches
____ Head Injury
____ Concussion in the past 3 years

HEMATOLOGIC
____ Hemophilia
____ Sickle Cell Anemia

DIGESTIVE/RECTAL/URINARY
____ Inability to void w/o Catheterization

MUSCULOSKELETAL
____ Spina Bifida

NEUROLOGICAL
____ Neurological Problems
____ Cerebral Palsy
____ Seizures
____ Postural Orthostatic Tachycardia Syndrome (POTS)

PULMONARY
____ Cystic Fibrosis

REPRODUCTIVE
____ Debilitating Menstrual Cramps

OTHER
____ Genetic Disorder
____ Immune Deficiency
____ Inability to tolerate extreme heat

____ **Other:** ____

____ **Asthma** (*If checked, please mark what may bring on this child's asthma)
____ Pollens ____ Animals ____ Illness ____ Weather Changes ____ Smoke ____ Perfume
____ Dust ____ Foods ____ Heat ____ Scents ____ Candles ____ Seasonal Changes
____ Other: ____
*What asthma symptoms does this child have? ____ Coughing ___ Shortness of Breath ____ Wheezing
Other symptom____

____ Allergic Reaction confirmed by a medical provider to: __ Stinging Insects __ Red Dye __ Latex __ Animals
__ Food(s): ____
__ Medication(s): ____
*What allergic reaction does this child have? ___ Itching ___ Hives/Rash ___ Wheezing ___ Swelling of Lips, Mouth, Tongue, Throat ___ Nausea/Vomiting/Stomach Cramps ___ Coughing ___ Shortness of Breath ___ Dizziness ___ Unconsciousness ___ Other ____

Parent/Guardian completing form signature: ______________________________ Date ______ Time ______