WARREN COUNTY STUDENT HEALTH AND INFORMATION FORM FOR 2020-2021

PLEASE READ HEALTH PACKET BEFORE COMPLETING

Child's Name_____ DOB _____
(Last) (First) (Middle)

Mailing Address: _____

Physical Address *(if different from above address)*_____

Email of Student:_____ Email of Parent/guardian_____

Child lives with: *(check one)* ☐ Parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Mother's Name:_____Home #_____Work #_____
Mother's Cell #_____

Father's Name _____ Home Phone # _____

Father's Work Phone # _____ Father's Cell Phone # _____

Legal Guardian's Name _____Home Phone # _____

Legal Guardian's Work Phone # _____ Legal Guardian Cell Phone # _____

Emergency Contact's Name (1):_____ Home Phone # _____

Emergency Contact's Work Phone # _____Emergency Contact's Cell Phone # _____

Emergency Contact's Name (2):_____ Home Phone # _____

Emergency Contact's Work Phone # _____Emergency Contact's Cell Phone # _____

List two people who will assume temporary care of your child if parents cannot be reached:

Name _____Phone # _____

Name _____ Phone # _____

Does the student have any health problems ☐ Yes ☐ No

*List any medications taken daily: (At home) _____

*List any medications taken daily: (At school) _____

*List any medications needed in a medical emergency: _____

Important Medical Information
(Please put a check beside all health problems your child has)

☐ Asthma	☐ Seizures	☐ Dairy Intolerant
☐ Diabetes	☐ Sickle Cell	☐ ADHD
☐ Vision- wears glasses	☐ Hearing	☐ Nose bleeds
☐ Heart	☐ Allergies - seasonal	☐ Allergies - food

Please list any allergies: _____

Please list any hospitalizations/surgeries or any other health problems: _____

_____

* For medications taken at school, a *Medication Administration Form must* be completed by physician and on file at school. The *Medication Administration Form* can be found in the Health Packet.

Permission to Release Student Form

Name of Student _____ Grade _____
(first) (middle) (last)

Name of Parent(s)/Guardian(s)_____

Please be sure to include the names of all persons who might pick up your child. Understand that if the person i not listed below, he/she will not be allowed to pick up your child. The individual will need to bring identification in the form of a driver's license or identification card when he/she picks up your child. A student will not be released under any circumstances to anyone whom has no proof of identification or anyone who is not listed on this form. **Please be sure to list yourself (parents and guardians) below.**

By signing in each signature box below, I authorize the following persons to pick up my child from school. I understand that if I chose to revoke this permission, I must come to the school and sign the last column which will make take away permission for that person to pick up my child. I understand that if I choose to add someone to this list, I must come to the school and add their name (s) to this list along with my signature.

Parent/Guardian Signature (s) _____

Name of person authorized to pick up above listed child (Please be sure to write their name as it appears on their identification)	Phone number	Relationship to Student	Parent/Guardian authorization signature (please sign each line indicating your permission for this person to pick up your child)	Parent/Guardian revocation of authorization (sign this line only if you no longer wish for this person to be able to pick u your child)
		Parent/Guardian		
		Parent/Guardian		

This authorization is valid for the 2018-2019 school year and will remain effective until a new list is received from the parent/guardi in the next school year.

NOTE TO TEACHERS: PLEASE MAKE A COPY FOR THE CLASSROOM AND RETURN THE ORIGINAL TO THE OFFICE ON THE DAY Y RECEIVE IT. IT MUST BE KEPT IN THE OFFICE AT ALL TIMES. Teacher/Grade _____

Warren County Schools
School Health Services

Medication Permission Form

STUDENT *Date of Birth*				Parent Legal Guardian
	YEAR		Bus Car	Cell Phone
Teacher				Work Phone
Grade ____				Home Phone

Name of Medication	___ mg per tablet ___ mg per teaspoon/5ml	take ____ tablet(s) take ____ teaspoons take ____ puffs	Total____ mg per dose	**TIME TO TAKE** ___ after lunch ___ as needed ___ before PE/recess

Reason for Medication __ADHD __Headache/Migraine __Fever/Pain __Asthma __Allergy

Side Effects / Precautions _____

START DATE ____/____/____ STOP DATE ____ / ____ / ____

☐ **Supervised Administration: School Staff will keep and give this medication for this student.**

☐ **Self-Administered Emergency Medication: Student is capable to keep/take this medication on his/her own.**

SELF CARRIED MEDICATIONS: INSULIN, GLUCAGON, EPI-PEN AND INHALERS ONLY

Parent Signature for self administration._____ **Parent to bring extra for med box.**

- Healthcare Provider *Signature*_____
- Healthcare Provider (PRINT)_____Date_____Phone_____

TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administering of the medication, and this medication must be prescribed by the licensed physician. I hereby release the school board and its agents and employees from any and all liability that may result from my child taking the prescribed medication. I also authorize my child's medical care provider to release information to the school nurse that is deemed necessary for the administration of medication at school in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I agree to provide and maintain an emergency phone contact. This consent is good for the school year, unless revoked.

➢ ***Parent/Legal Guardian Signature***_____ ***Date*** _____

DAYTIME PHONE NUMBERS _____

Teachers Receiving Copies(Include Date)_____

☐ Student demonstrates adequate knowledge to keep, carry and take this medication.
School Nurse _____ Date_____

BUS DRIVER NOTIFIED _____ BUS NUMBER_____

File original in Individual Health Record *Copy to staff administering medication*
SS-157 *Revised: July 2013*

WARREN COUNTY SCHOOLS
SCHOOL HEALTH SERVICES
109 Cousin Lucy's Lane
PO Box 110
Warrenton NC 27589

Dear Parent/Guardian:

The Healthy Youth Act of 2009 requires all school systems to provide a health education program that meets requirements set by the General Assembly. In an effort to provide the students of Warren County Schools' informative reproductive health education, sessions are presented to grades Pre-K – 9th and other classes as requested for grades 10-12. Topics discussed with all grades will include reproductive health safety such as good health practices and strategies for good health decisions.

Your child's class will be (see below):

Pre-K – 3rd will have classes entitled "Good Touch, Bad Touch" and "Stranger Danger". These classes include body safety and violence prevention. The students will learn safety tips and how to respond when someone touches them inappropriately.

Grades 4 – 5 will primarily discuss how their bodies change during puberty, how to be prepared for these changes and personal hygiene. Warren County Schools uses the nationally recognized Proctor and Gamble program called Always Changing.

Grades 6 – 9 will be presented "Making Proud Choices", An Evidenced-Based, Safer-Sex Approach to Teen Pregnancy, STD and HIV Prevention.

At all levels the programs presented are designed to help students think through important life decisions. Information covered will allow students the ability to choose between negative pressures that push them toward sexual activity and positive life choices that encourage freedom to choose their future.

Parents will be notified again, prior to the classes. You are encouraged to preview the materials and can do so by calling School Principal, School Nurse or School Counselor to set up and appointment for viewing. **Any parent or guardian wishing to withhold permission for their child to participate must complete the form below. However, if you are in agreement of your child participating, do not return the Denial Form below.**

Sincerely,

Principal

Reproductive Health and Safety Education Denial Form

IF YOU DO NOT WANT YOUR CHILD TO PARTICIPATE

Please fill out-the- Reproductive Health and Safety Education Denial Form below and have your student return it by the end of the first week of school. Please contact the school if you have any questions or concerns.

Parent/Guardian of _____ (student)
I **DO NOT** wish for my child to participate in the Reproductive Health and Safety Education class(es) as described above for my child's grade level.

_____	_____	_____
Parent's Signature	Parent Name (Printed)	Date