SCHOOL/HOMEROOM:_____ **GRADE:** _____

CONSENT FOR SCHOOL HEALTH SERVICES/MEDICATION ADMINISTRATION

PIKE COUNTY HEALTH DEPARTMENT/PIKE COUNTY SCHOOL SYSTEM/PIKEVILLE INDEPENDENT SCHOOLS

CHILD'S NAME:_____**BIRTHDATE**:_____**GENDER** _____**RACE**: _____

ADDRESS:_____

CHILD'S SOCIAL SECURITY #: _____ **HOME PHONE**:_____ **WORK PHONE**:_____

EMERGENCY CONTACT NAME:_____**PHONE** _____
(Other than Parent)

KY MEDICAID ID# (if applicable):_____**NUMBER IN HOUSEHOLD**:_____

MANAGED CARE ORGANIZATION: (circle one) AETNA WELLCARE ANTHEM HUMANA PASSPORT
MCO POLICY NUMBER:_____

STUDENT'S DOCTOR:_____ **DOCTOR'S PHONE**:_____

STUDENT'S DENTIST:_____ _____**DENTIST'SPHONE**:_____
SEIZURES_____

ALLERGIES/ASTHMA (food, insects, medication, latex, fluoride, other)_____
CURRENT MEDICATIONS_____
CHRONIC MEDICAL ILLNESSES_____

SIGNIFICANT MEDICAL / SOCIAL HISTORY (Including Injuries) _____

SIGNIFICANT FAMILY MEDICAL HISTORY Hypertension ☐ High Cholesterol☐ Diabetes☐ Other_____ ☐

Please check any of the following, which you will allow your child to be given, and state dosage if necessary. All doses not specified will be given according to the child's age and weight using manufacturer's guidelines.

	Advil/Motrin (Ibuprofen)		Benadryl		Orajel (toothache) Chloraseptic (sore throat)
	Aloe Vera (for burns)		Cold Remedies (cough syrup, decongestant)		Sun Screen (SPF 15 or above)
	Antacids (Maalox, Tums, etc.)		Diarrhea Medication		Topical Antiseptics
	Antibiotic Ointment (Neosporin)		Eye Drops (Visine, Murine, etc)		Tylenol (acetaminophen)
	Anti Nausea/Anti Vomiting		Hall Mentho-lyptus cough drops		
	Anti-itch Spray or Lotion (insect bites, etc.)		Hydrocortisone Cream (for itching)		

Additional instructions of consideration:_____ The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency.Please check the appropriate space if your child has ever had any of the following:

	Anemia		Asthma		Persistent Cough		Exposed to Tuberculosis
	Birth Defects		Chest pain		Leukemia		Shortness of breath
	Diabetes		Seizures		Sleep Problems		Head, Eyes, Ears, Throat Problems
	Chicken Pox		Unexplained Weight Loss/Gain		Stomach or Bowel Problems		Blood Transfusion
	Rheumatic Fever		Unexplained tiredness		Joint or Muscle Pain or Stiffness		Anaphylactic Episodes

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

I consent to care at the school provided by the Pike County Health Department which may include screenings such as Scoliosis screening, vision and hearing exams, assessments, lab tests, treatment, first-aid, over the counter medicine, and any other health service given to me/my child by staff or agents of the Pike County Health Department. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I like-wise release the staff from any liability related to the administering of the above medications to my child so long as the treatment is provided according to the above instructions. I authorize the school health clinic to release medical information about my child, as permitted by the Health Insurance and Portability and Accountability 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 understand that the information obtained for the school physical, including immunization information, will be released to my child's school. If my child has Medicaid or KCHIP, I also authorize the school clinic to release this information to those agencies so that the Medicaid or KCHIP can be billed for visits to the school clinic. This permission can be revoked at any time. No services will be provided unless the signed form is returned. I agree to provide the agency nurse an order from my child's physician for any prescription medications before they can be given. **I also understand by signing this consent, I acknowledge that I may request a copy of the Pike County Health Department's Privacy Notice by calling the Pike County Health Department's main office at 437-5500 or have access to a copy of the Pike County Health Department's Privacy Notice located at**
www.pikecountyhealth.com/v3/uploads/documents/pchd_hipaa_pp.pdf .

Signed:X_____ Printed:_____ Date:_____
(Parent or Guardian) (Parent or Guardian)