



**Long County School Health Services  
Annual Student Health Information  
Confidential**

**PARENT - PLEASE COMPLETE, SIGN & RETURN TO THE SCHOOL NURSE**

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Home Room Teacher \_\_\_\_\_ School \_\_\_\_\_

**Health History – Does your child now have or has he/she ever had:**

Asthma	Yes / No	Learning Disability	Yes / No	Wears hearing device/aid	Yes / No
Diabetes	Yes / No	Hearing Problems	Yes / No	Physical Education Limitations	Yes / No
Seizure Disorder	Yes / No	Vision Problems	Yes / No	Other illness (list)	
Physical Limitations (list)	Yes / No	Wears glasses/contacts	Yes / No	<b>List Any Allergies:</b>	

	Yes	No
Heart Problem/Defect		
ADD/ADHD		
Anemia (include sickle cell)		
Arthritis		
Back/Neck Injury or Condition		
Blood/Clotting Disorder		
Cancer/Leukemia		
Diet Restrictions		
Head Injury/Concussion		
Headaches		

	Yes	No
Mononucleosis		
Hepatitis		
Surgery		
Physical Disability		
Other (explain below)		
Immunizations up to date		

**IF YOUR CHILD HAS ASTHMA**

Will he/she need to carry his/her inhaler at school? **Yes / No** If yes, please contact School Nurse.\*

**IF YOUR CHILD HAS A SEVERE ALLERGY**

Will he/she need to carry his/her EpiPen at school? **Yes / No** If yes, please contact School Nurse.\*

**Please explain any YES answers given in the health history above. Give as much information that will help your school nurse understand and assist with your child's needs. Include a separate sheet if additional info is necessary:**

\_\_\_\_\_

\_\_\_\_\_

List any medications taken at home (prescribed or over the counter (OTC): \_\_\_\_\_

**(Please see your school nurse for a *School Medication Authorization Form* if student needs to take prescription medication at school or to carry inhaler or epi-pen.**

Any other information/instruction/legal restrictions that would be significant in the care of your child? **Yes / No**

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES**

I hereby give my consent for my above named child to participate in the School Health Services Program, which may include vision, hearing, height, weight, body mass index, nutrition, dental, &/or scoliosis screenings, health appraisals, & nursing assessment.

In case of minor accidents or illness, I hereby give my consent for my child to receive routine first aid administered by school personnel. I also give permission for the use of the following over the counter and emergency preparations when needed in the event of minor skin irritation/injury, or for minor pain, discomfort or fever.

Over the counter medications will only be used according to the label directions for the listed purpose and age/size of the student. No over the counter medications will be used more than 5 consecutive or 30 cumulative school days per semester without a doctor's order. If an "over the counter" medication is required by a student more than 3 times, the parent will be required to furnish that medication for future need. Over the counter medications will only be provided at the discretion of the school nurse. This standing protocol medication procedure is established for the purpose of aiding student attendance, minimizing student discomfort so that they may be more attentive in class, to assist parents by not having to leave their jobs to come to the school every time a student has a minor discomfort or injury and to sustain life in the event of a life threatening emergency.

**STRIKE THROUGH and INITIAL ANY OF THE FOLLOWING MEDICATIONS THAT YOU DO NOT WANT TO BE USED FOR YOUR CHILD**  
*Generic Preparations may be substituted for these listed over the counter products. The Long County Schools will not be required to furnish medications but will have these on hand as funds are available.*

Tylenol	Benadryl /Caladryl <b>Topical</b>	Saline/Visine/contact rewetting eye drops	Sting Kill/AfterBite swabs/cream
Motrin	Calamine lotion <b>Topical</b>	Oragel/Anbesol	Burn cream or spray
Maalox/Mylanta	1% Hydrocortisone <b>Cream</b>	Sore throat lozenges	Benadryl liquid/tablets
Tums/Roloids	Neosporin cream/ointment	Cough Drops	Antiseptic wash

- ❖ I understand that prescription or over the counter medications of any kind are not allowed on school grounds without the proper medical authorization on file and must be brought to the school by the parent/guardian or designated adult.
- ❖ I understand that school staff, including the nurse MAY NOT administer or assist with any medication without the proper medical authorization on file.
- ❖ I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information to be shared, I must request this in writing and file it with the school nurse.

In case of an accident or illness where immediate treatment of my child is not indicated but where he/she is unable to remain at school, I request that one of the following be contacted to care for my child in the event that neither parent or legal guardian can be reached.

Name	Relationship	Home phone	Work phone	Cell phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

In the event of a major accident or serious illness, I understand the school will make every effort to contact me. School clinic personnel have permission to contact my child's health care provider and/or pharmacist if medically necessary. I, the parent /legal guardian, authorize the transport and treatment by Emergency Medical Services and the hospital emergency staff for my above listed child. Fees for transport and medical services will be the responsibility of the Parent/Guardian signed below.

**Preferred hospital- Please circle one: Wayne Memorial Liberty Regional Medical Center Winn Army Community Hospital**  
 We will make every effort to transport your child to the above facility; however, transportation to this site cannot be guaranteed.

**Date** \_\_\_\_\_ **Parent/Guardian Signature** \_\_\_\_\_  
 Parents/Guardians Name(s) \_\_\_\_\_

Notes to parents often get lost by students. If you have an email address, this is the quickest way to contact you if your child is seen in the clinic for anything other than emergencies.

E-mail address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

**OR**

**I DO NOT** want my child to receive school health services. I agree to be **immediately available** to provide care for my child at school at **ALL TIMES**.

**Date** \_\_\_\_\_ **Parent/Guardian Signature** \_\_\_\_\_