School Nurse Health Information (Emergency Card)

Student: _____ / _____ / _____ / _____ ❑ MALE ❑ FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

EMERGENCY CONTACT INFORMATION

Parent/Guardian:

_____/_____/_____/_____/_____
Name Relationship Work Phone Home Phone Cell Phone

_____/_____/_____
Street Address City Zip

_____/_____
Email Address Occupation

Parent/Guardian (if different from above):

_____/_____/_____/_____/_____
Name Relationship Work Phone Home Phone Cell Phone

_____/_____/_____/_____
Street Address City Zip E-mail

_____/_____
Email Address Occupation

Please list below three people who have your permission to pick your child up from school and make decisions concerning your child in the event that you cannot be reached.

Name of Person	Relationship	Telephone
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Every school has a nurse assigned to them and first responders trained in CPR and First Aid. The nurse may not be on the school campus at all times. In the event of an emergency, the school staff will contact 911 and follow their instructions. Every attempt will be made to contact a parent, guardian, or a designated emergency contact.

Hospital Choice _____ **Doctor's Name** _____ **Doctor's Phone** _____

Insurance/Medicaid # ☐☐☐☐☐☐☐☐☐☐

By my signature below, I consent for Charleston County School District (CCSD) to provide Non-IEP Nursing Services (such as routine medications, accident and injury care) to my child, release and exchange information about the service provided along with my child's name, date of birth, Medicaid or health insurance number, gender, and my contact information to the Medicaid Agency (Department of Health and Human Services), to bill and receive payment for the nursing services from the Medicaid Agency. I understand that Medicaid reimbursement for Non-IEP Nursing services provided by CCSD will not affect any other Medicaid services for which my child is eligible. CCSD will continue to provide Non-IEP Nursing services for my child at no cost to me even if I refuse to allow billing for services. Granting consent is voluntary and may be revoked at any time. Revocation is not retroactive. The District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of Non-IEP Nursing services.

Parent /Guardian/ Student (if 18) Print name _____

Signature_____ **Date** _____

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Student: _____ / _____ / _____ / _____ ❑ MALE ❑ FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

Medication/Medical Procedures: (CCSD policy JLCD-Assisting Students with Medications) Any prescription medication or medical procedure (blood sugar check, tube feeding) to be administered at school or school related activities must be accompanied by written orders from a health care practitioner. Limited over-the-counter medications may be administered by the school RN or LPN with parent consent. Complete consent below. All information below is confidential for the school nurse and may be shared on need to know basis for student safety.

Screenings: CCSD school nurses conduct vision, hearing, blood pressure, BMI and dental screenings, as time permits, based on DHEC recommendations. Contact your school nurse if you do not want your child to participate. Head Start and Early Head Start follow program requirements for vision, blood pressure, BMI, dental, lead and developmental screenings.

(OTC) Over the Counter Medication	Check or Initial Each	I consent for the Charleston County School District RN or LPN to administer the OTC medication as indicated below. Medication will be administered following the policy JLCD. _____**Acetaminophen** _____**Ibuprofen** _____**Hydrocortisone Cream** _____**Anti-fungal Cream** _____**Antibiotic Ointment**

Please address each yes/no question

Health History:

ADD/ADHD	**❑YES❑NO**	❑Takes Medication at Home ❑Needs Medication at School:_____ ADD/ADHD Doctor's Name:
Allergy	**❑YES❑NO**	❑Environmental/Seasonal ❑Takes Medication at Home ❑Needs Medication at School _____ ❑Severe (Life Threatening) to: _____ ❑Emergency Medication (Epi-Pen/ Auvi-Q) ❑Does Not have epinephrine at school Last date Epi-Pen used ____/____/_____ Allergy Doctor's Name:
Asthma	**❑YES❑NO**	❑Daily Maintenance Medication ❑Rescue Inhaler ❑Rescue Nebulizer ❑Does not use/have an inhaler Asthma Doctor's Name:
Cardiac (Heart)	**❑YES❑NO**	❑Takes Medication at Home ❑Needs Medication at School: _____ Heart Doctor's Name:
Diabetes	**❑YES❑NO**	❑Type 1 ❑Type 2 ❑Blood Glucose Checks ❑Oral Medication ❑Carb Counting ❑Takes Insulin ❑Shots ❑Pump ❑Glucagon Diabetes Doctor's Name:
Epilepsy (Seizures)	**❑YES❑NO**	❑Daily Medication ❑Diastat ❑Other Needs/Treatments ❑Date of Last Seizure ___/___/___ Seizure Doctor's Name:
Sickle Cell Anemia	**❑YES❑NO**	❑Trait ❑Disease ❑Takes Medication at Home ❑Needs Medication at School_____ ❑Last Hospitalization ___/___/_____ Sickle Cell Doctor's Name:
Physical Limitation	**❑YES❑NO**	Type _____ ❑Limitation ❑Assistive Device Required ❑Takes Medication at Home ❑Needs Medication at School Disability Doctor's Name:
Mental Health Consideration	**❑YES❑NO**	Type _____ ❑Takes Medication at Home ❑Needs Medication at School_____ Mental Health Provider's Name:
Hearing Consideration	**❑YES❑NO**	❑Hearing Aids ❑Cochlear Implant ❑Other
Vision Consideration	**❑YES❑NO**	❑Glasses (reading) ❑Glasses (distance) ❑Contacts ❑Other
Feeding Consideration	**❑YES❑NO**	❑Swallowing ❑G-tube feeding at school
Elimination Consideration	**❑YES❑NO**	❑Diapering ❑Catheterization at school ❑Encopresis
Other	**❑YES❑NO**	Describe:

Parent / Guardian Signature_____ **Date** _____