Livingston County Schools Health Service Clinic

Affiliation with Wright Medical

(Dr. Alex Wright)

2023-2024 SCHOOL HEALTH PACKET

Please complete the attached form and return to school by December 15th

This will take the place of the current form on file from the Graves County Health Department.

Dear Parent/Guardian:

Beginning January 1st, 2024, school-based health clinics are a part of Wright Medical and are available to provide medical and population health services. Some common services are:

- Sick child assessment and treatment
- Required screenings such as vision, hearing, and scoliosis
- First Aid

The attached consent & general information must be completed and signed in order for your child to be seen by the school nurses. **All insurance information must be complete.** Some of the information is for statistical/reporting purposes. If you any questions, you may talk to your child's school nurse or you can call Amy Ramage, Director of Pupil Personnel at the Livingston County Board of Education.

There is **NO CHARGE** to the students or parents for school nursing services.

If your child has a chronic medical condition, such as asthma, diabetes or ADD/ADHD or requires emergency medication such as inhalers, Epipens, seizure medications, etc please ensure that there is an action plan from your child's physician on file with the school nurse. Please make plans to meet with the school nurse to establish a plan of care for your child. The appropriate form must be completed before medication can be dispensed at school. If you currently have medication at school the school nurse will be contacting you via phone to explain the transfer process.

Please be aware, due to unforeseen reasons, there may be times during the school year there will not be a nurse available. Each school will have a trained unlicensed staff that will be able to dispense daily and emergency medication.

**Also for your child to be seen by Dr. Wright for acute visits the completed form for Wright Medical will also need be on file. Copies of these forms are available at each school and at each school clinic. You may also receive a copy of the form by calling 270-928-2111 and asking for either Amy Ramage or Nora Emmons.

Cardinal Clinic – NLES/LCMS – 270-988-2394
LCHS Clinic – LCHS – 270-928-4263
Mustang Clinic – SLES – 270-928-3915

2023-2024 Livingston County Schools Health Services Clinic

General information Please Print (**Complete both sides of form please)**

Last Name _____First Name _____ Full Middle Name _____

Address _____

PO Box/Street City Zip

Birth Date _____ **Is student in Foster Care? Yes or No**

Race: ___ White ___ Asian Gender: ___ Male
___ Black ___ Hispanic or Latino ___ Female
___ Hawaiian/Other Pacific Islander ___ American Indian/Alaska Native
___ Other

Who does the child live with? (Name & relationship) _____phone# _____

Mother's name _____ cell# _____ work# _____

Father's name _____ cell# _____ work # _____

Email _____ County of Residence _____

Insurance Information: Check all that apply - Must be completed in order for your child to be seen by Nurse.

___ **Medicaid (Managed Care)** – Please circle one: Atena Anthem Humana Well Care Passport United Healthcare

Medicaid # _____ MCO # _____

___**Private Insurance**: Insurance Name: _____ ID# _____

Group # _____

Does insurance cover all immunizations: ___ Yes ___ No Preferred Pharmacy_____

Claims address _____

Child's Physician _____ Phone Number _____

Please check only the medications you give permission for your child to receive (Generics may be given)

_____ Acetaminophen (Tylenol, etc.)
_____ Ibuprofen (Motrin, etc.)
_____ Eye Drops (Visine, Murine, etc.)
_____ Cough Drops, Warm Salt Water
_____ Anti-itch Cream
_____ Benadryl
_____ Antacid (Tums)
_____Benzocaine
_____ Skin Irritant Relief (Lanacaine, Aloe Gel, etc.)
_____ Toothache Relief (Anbesol, OraJel, etc.)
_____ Topical Antibiotics (Neosporin, Triple Antibiobic, etc.)
_____ Topical Antiseptics (Alcohol, Hydrogen Peroxide, etc.)
_____ Mouth Sore Relief (Blistex, Carmex, etc.)
_____ Muscle Cream
_____ Pepto-Bismol

Please note that if your child receives medication daily, such as for diabetes, asthma, ADD/ADHD a different form along with this consent is needed. You can pick up a form at the Nurse's office.

In case of **Emergency**, if unable to reach parent, whom should we contact? (Should be same as school information)

	Name	**Relationship**	**Home#**	**Cell#**
1.				
2.				
3.				

Does your child have glasses or contacts? _____ Yes _____ No If yes, does he/she wear them? _____Yes _____ No
Student's Homeroom Teacher _____ Grade for 2023-2024 school year: _____
Name: _____

Please check all that apply:

_____ No known food or drug allergies

_____ **Allergies to food, medication or insects:** list all allergies: _____
Does your child have a prescription to carry an EPI Pen? _____
_____ Current Medications: _____
_____ Past surgeries/hospitalizations: _____
_____ Long-term illness: circle all that apply
Asthma/breathing problems Diabetes Heart problems Epilepsy/Seizures
Other: _____
Does your child carry an inhaler? _____ Yes or _____ No
Is your child currently under physician's care for the above condition? _____ Yes or _____ No
Name/Phone Number of Physician _____

CONSENT TO HEALTH SERVICES

I give my consent for (Print students Name) _____ (Birthdate) _____
to receive services at the Livingston County Schools Health Services Clinic.

Provided as needed if consent signed
Vision, scoliosis & hearing as requested by the school

Daily medications will only be given to students who have a signed "Prescription for Daily Medication" consent form completed by their physician. All necessary forms must be completed prior to administration of medication at school. All medication must be brought to clinic by a parent or guardian.

I authorize the release of medical information such as: vaccine certificates, vision exams/screenings, physical exams to my child's school health clinic for the purpose of state compliance.
I understand that no guarantees being made as to effect of any exam or treatment given to my child. I likewise release the staff from any liability related to the administering of any over-the-counter medicine as long as the responsibility is discharged according to the label instructions or per protocol. I authorize the school health clinic to release medical information about my child to his/her primary care provider and to share pertinent medical information (such as allergies or significant medical history) to school staff that may need to provide care to my child in emergency. The sharing of any information is only on a need to know basis. **I understand that if I do not sign this consent or if I alter this consent in any way, care may not be given to my child: however in the event of an emergency 911 will be called.**
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. This consent is good for this school year only 2023-2024.

Signature of Parent/Guardian Printed Name of Parent/Guardian Date Signed

CHILD CANNOT BE SEEN IN THE SCHOOL CLINIC WITHOUT THE GUARDIAN SIGNATURE