*****COMPLETE FORM. SIGNATURE REQUIRED. RETURN TO SCHOOL NURSE *****

SCHOOL YEAR:

Bracken County Health Department Consent for Health Services

Child/Student Information

Teacher _____ Grade_____ Child's Social Security #_____

Child's Last Name_____ First Name_____ MI_____ Birthdate:_____

Street Address:_____ City_____ Zip_____

Parent/Guardian_____ Primary Contact No._____ Secondary Contact:_____

Parent/Guardian _____ Primary Contact No _____ Secondary Contact:_____

Emergency Contact Person **OTHER** than guardian or parent_____ Contact No._____

My child **HAS** the following life threatening condition that requires **EMERGENCY** treatment or medications to be given at school.

___**DIABETES** ___**ASTHMA**___**SEIZURES**___**SEVERE ALLERGY (LIST:_____) OTHER**_____

Child's Medical History

Significant medical history:

_____

Medications taken on a regular basis _____

Allergy to **MEDICATIONS:**_____

Child's Health Care Provider :_____ Child's Dentist:_____

Consent for Health Services/Authorization for Insurance Billing/Release of Information :

I consent to care which may include screening, exams, assessments, lab tests, treatment ,first aid, over-the-counter medicine, and any other health services given to me/my child by staff of this school health clinic site. I understand no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to release medical/dental information about my child to his/her primary care or dental provider. By signing below, I authorize Bracken County Health Department to file benefit claims on my behalf, and to release any information necessary for the processing of such claim(s) to my child's insurance provider. This authorization shall remain in effect for the current school year (1) year. I understand that Bracken County Health Department will adhere to the confidentiality and care standards as mandated in the Health Insurance Portability and Accountability Act (HIPPA). A summary of these rules is located in the School Clinic.

X

_____ _____

Signature of Parent/Legal guardian/Emancipated student **Date**

School Year:

Permission Form for Over the Counter Medication

****ALL MEDICATIONS MUST BE PROVIDED BY PARENT/GUARDIAN AND TURNED IN TO THE OFFICE WHEN ENTERING SCHOOL..****

Child's Name_____ ____/____/_____ [ ] Female [ ] Male
(Please Print) Last First Middle Date of Birth

TO BE COMPLETED BY THE PARENT/GUARDIAN: I give permission for my child to receive the below medication at school according to school policy (09.2241) throughout this school year. I release Bracken County School Board and its employees from any claims or liability connected with its reliance on this permission.

X_____ _____
Parent/Guardian's Signature Date

PLEASE CHECK ALL THAT APPLY	OVER THE COUNTER MEDICINE	FOR WHAT SYMPTOMS	DOSAGE
	ACETAMINOPHEN / TYLENOL		
	ALOE VERA		
	ANTIBIOTIC OINTMENT		
	BENADRYL (DIPHENHYDRAMINE)		
	CALAMINE LOTION		
	CARMEX		
	COUGH DROPS / SYRUP		
	EYE DROPS		
	HYDROCORTISONE CREAM		
	HYDROGEN PEROXIDE / RUBBING ALCOHOL		
	IBUPROFEN / MOTRIN		
	MUSCLE RUB		
	ORAGEL		
	PEPTO BISMOL/IMMODIUM/ ANTACIDS		
	SUDAFED		
	OTHER:		

TO BE COMPLETED BY SCHOOL PERSONNEL

School:_____ Date form received:_____

I/we acknowledge receipt of the Parent Authorization for OTC Medication:_____