

Bamberg School District One

Confidential School Health History and Consent Form

School Year: 2021-2022

Student: _____ DOB: _____ Sex: _____ Grade: _____
 Address: _____ City: _____ Zip: _____

Mother/Guardian: _____ Home #: _____ Work #: _____ Address: SAA() _____ City: _____ Cell #: _____	Father/Guardian: _____ Home #: _____ Work #: _____ Address: SAA() _____ City: _____ Cell #: _____
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Emergency Contact Name: _____ Phone: _____
 Does your child have medical problems or receive any treatment for medical problems? _____ Yes _____ No
 Has your child had surgery or been hospitalized? _____ Yes _____ No

Is your child allergic to any of the following? Please check YES or NO.				
Yes	No	Type of Allergy*	List allergy ex. (aspirin, ants, nuts)	Describe reaction ex.(rash/hives / stomach upset)
		<i>Medicine allergy</i>		
		<i>Insect allergy</i>		
		<i>*Food/beverage allergy</i>		
<i>*Requires the use of an Epi-pen or Benadryl for severe allergic reaction (medication will be sent from home).</i>				
<i>*A doctor's note is needed when a student has a food or beverage allergy and requires a change in the school menu.</i>				

Does your child have any of the following medical conditions? Please check YES or NO in the boxes located BEFORE each medical condition listed below. *If your answers is yes to any condition, please explain on the back of this form.							
Yes	No		Yes	No		Yes	No
		Asthma (see back of form)			ADD/ADHD		
		Cancer			Neurological/brain/spine/CP		
		Diabetes			Orthopedic (bone/joint)		
		Epilepsy/Seizures (see back)			Skin rash/eczema		
		Frequent headaches			Urinary (kidney/bladder)		
		Frequent ear infections			Sickle cell disease		
		Heart Murmur/Problem			Tuberculosis		
		Hemophilia/free bleeding			Emotion/behavior problem		

What is your child's Doctor's name? _____ Phone #: _____
 What is your child's Dentist's name? _____ Phone #: _____
 What is your child's payment source for medical care? _____ Medicaid _____ Health Insurance _____ None

Permission for Service
<p>**I give my permission for my child to receive medical treatment as deemed necessary by the school nurse or designated staff.</p> <p>**I understand that prescription and over-the-counter medication may be given at school with a doctor's order. All over-the-counter medication must be labeled by the pharmacist as set forth in SC Code Ann.40-43-86. All medications must be in their original bottle or package and both prescription and over-the-counter medication must be labeled by the pharmacy. All medications must be secured in the school nurse's office unless a student has approved authorization for self-medicating. Students should not transport medication to school. The nurse may refuse to administer any medication which does not meet these guidelines.</p> <p>**I understand that authorization forms for self-medication and self-monitoring must be completed by the student's medical provider, the parent, and the student. Also, the indemnification Form for self-medication and/or self-monitoring must be signed by the student and the parent. No student will be allowed to self-medicate or self-monitor until all forms are completed and signed.</p> <p>**I understand that in case of emergency and I cannot be reached, my child will be transported to the nearest emergency room by Emergency Medical Services (EMS). I understand that I am responsible for all expenses associated with the emergency.</p> <p>**I understand that Bamberg School District One offers health screenings (vision, hearing, growth, dental, blood pressure) when possible for students and follows the S.C. Department of Health and Environmental Control (DHEC) guidelines and recommendations.</p> <p>**I understand that information about my child will be shared on a "need to know" basis within the school/district and the school will share information with the S.C. Department of Health and Environmental Control (DHEC) and EMS as needed or when necessary.</p> <p>Parent/Guardian Signature: _____ Date: _____</p>

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Please list any medications that your child takes:

Name of Medication	Dosage	Time	Doctor who Prescribed

Please contact your child's school nurse with questions or to obtain a medication permission form.

Please explain any medical problem or condition: _____

*If you answered yes to seizures or asthma on the front of this form, please complete the section below.

YES	NO	Type of Seizure	Date of last seizure	YES	No	Asthma management	Date of last episode
		Febrile (with fever only)				Medication taken daily	
		Focal or Absent				Seasonal flare-ups only	
		Grand mal seizure				History Only – no flare ups in over 3 years	

Please list the names of anyone who would be allowed to pick up your child if he/she were sick:

#	NAME	RELATION	DAY PHONE	CELL NUMBER
1.				
2.				
3.				
4.				
5.				
6.				

Please notify your child's school nurse when phone numbers change. It is important to have working numbers where you or your emergency contact can be reached in the event of a medical emergency.

Bamberg School District One is committed to providing your child with the safest school environment possible. When a child's symptoms or condition is listed on the South Carolina Department of Health and Environmental Control's School Exclusion List, we are required to exclude that child from school until he/she is well. With this in mind, we are asking all students stay out of school if they are sick.

This includes but is not limited to:

1. **Fever 99 F or greater.** A student must be fever free without the use of fever reducing medications for at least 24 hours before returning to school.
2. **Vomiting.** A student must be free from vomiting for at least 24 hours before returning to school or have a doctor's note stating that they can return to school.
3. **Diarrhea.** Three or more in 24 hours.
4. **Ring worm of the scalp.** A student may return after a medical examination and treatment.

If your child's illness keeps him/her from comfortably taking part in activities, requires more care than the staff can give without affecting the health and safety of other children or if other children could get sick from being near your child, please keep your child out of school.

Please encourage your child to help us reduce the spread of terms by:

- covering coughs and sneezes
- frequently washing hands
- staying home when sick

Check your child for head lice frequently and if found treat head lice as directed by your physician.