**Bamberg County School District**

*Empowering Every Child, Every Day.*

**School Year: 2024-2025**

**Confidential School Health History & Consent Form**

**Student:** _____ **DOB:** _____ **Sex:** _____ **Grade:** _____

**Address:** _____ **City:** _____ **Zip:**_____

| | | | |
|---|---|---|---|
| **Mother/Guardian:** | | **Father/Guardian:** | |
| **Cell #:** | **Work #:** | **Cell #:** | **Work #:** |
| **Address:** | | | |
| **City:** | **Home#:** | **City:** | **Home#:** |
| **Emergency Contact:** | | **Emergency Contact Phone #:** | |

**Does your child have any medical problems, receive treatment for medical problems or take any medication? ☐ Yes ☐ No >> If yes, please fill out the medical information boxes on the back of this page.**

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 ☐ Private Health Insurance ☐ None

**Bamberg County School District 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,:**

- **Fever (Temp 99 or greater).** A Student must be fever free without the use of fever reducing medications (Motrin, Tylenol, DayQuil, etc) for at least 24 hours before returning to school.
- **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.
- **Diarrhea.** Three or more episodes in 24 hours. Must be free from diarrhea for at least 24 hours before returning to school.
- **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/sneezes, frequently washing hands, and staying home when sick.**

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

## Permission For Service

- I give my permission for my child to receive medical treatment as deemed necessary by the school nurse or designated staff.
- 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.
- 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-medicating 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.
- The school district will stock a limited supply of the following life-saving medications: Epinephrine Auto-injectors and Intranasal Naloxone. The epinephrine auto-injectors will be used to treat a severe allergic reaction and the intranasal naloxone will be used to treat a drug over-dose. For any child who has a severe allergy, the guardian will still need to supply epinephrine since the school district supply is limited. Please note if any lifesaving medications are given, 911/EMS will be activated.
- 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.
- I understand that Bamberg County School District 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.
- 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.

**Parent/Guardian Signature:** _____ **Date:**_____

****Medical information to be entered on the back of this page. →**

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**⊕ ALLERGIES: Is your child allergic to any of the following? Please check YES or NO.**

| | Type of allergy? * | List allergen (ex: penicillin, ants, nuts): | Describe reaction (ex: rash/hives, swelling): |
|---|---|---|---|
| ☐**Yes** ☐**No** | Medication Allergy | | |
| ☐**Yes** ☐**No** | Insect Allergy | | |
| ☐**Yes** ☐**No** | **Food/Beverage Allergy | | |
| ☐**Yes** ☐**No** | *Does your child require the use of an Epi-Pen or Benadryl for a severe allergic reaction? ***If yes, this medication will need to be brought from home by a parent/guardian with prescription label and appropriate paperwork filled out.*** | | |

**A doctor's note is needed when a student has a food or beverage allergy and requires a change in the school menu.

**⊕ MEDICAL PROBLEMS: Does your child have any of the following medical conditions? Please check yes/no in the boxes to the left of the listed condition. Please provide further details below.**

| | | |
|---|---|---|
| ☐**Yes** ☐ **No** Asthma (see box below) | ☐**Yes** ☐**No** Epilepsy/Seizures (see box below) | ☐**Yes** ☐**No** Hearing issue/hearing aids |
| ☐**Yes** ☐**No** Cancer | ☐**Yes** ☐**No** Neurological (brain/spine/CP) | ☐**Yes** ☐**No** Vision issue/contacts/glasses |
| ☐**Yes** ☐**No** Diabetes | ☐**Yes** ☐**No** Orthopedic (bone/joint) | ☐**Yes** ☐**No** Emotion/behavior problem |
| ☐**Yes** ☐**No** Heart Murmur/Heart Problem | ☐**Yes** ☐**No** Skin (rash/eczema) | ☐**Yes** ☐**No** ADD/ADHD |
| ☐**Yes** ☐**No** Frequent Headaches | ☐**Yes** ☐**No** Urinary (kidney/bladder) | ☐**Yes** ☐**No** Autism/Developmental Delay |
| ☐**Yes** ☐**No** Frequent Ear Infections | ☐**Yes** ☐**No** High Blood Pressure | ☐**Yes** ☐**No** Under/Over weight |
| ☐**Yes** ☐**No** Hemophilia/Sickle Cell Disease | ☐**Yes** ☐**No** Feeding tube/G-tube | ☐ **Other:** |

**Please explain any medical problems/condition checked:** _____

_____

_____

_____

_____

**⊕ ASTHMA**

| Asthma Management | Date of Last Episode |
|---|---|
| ☐**Yes** ☐**No** Medication Taken Daily | |
| ☐**Yes** ☐**No** Seasonal Flare-Ups Only | |
| ☐**Yes** ☐**No** Exercise Induced Only | |
| ☐**Yes** ☐**No** History Only- no asthma flare-up in >3 yrs | |
| ☐**Yes** ☐**No** Does your student have a rescue inhaler for flare-ups/attacks (ex: albuterol)? | |

**⊕ SEIZURES**

| Type of Seizure | Date of Last Seizure |
|---|---|
| ☐**Yes** ☐**No** Febrile (w/ fever only) | |
| ☐**Yes** ☐**No** Focal or Absent | |
| ☐**Yes** ☐**No** Petit mal | |
| ☐**Yes** ☐**No** Grand mal | |
| ☐**Yes** ☐**No** Does your student have emergency medication for seizures (ex: Valium, Nayzilam)? | |

**⊕ MEDICATIONS: Please list any medication(s) that your child takes:**

| Name of Medication | Dose | Time Medication Taken | Doctor who Prescribed Medication |
|---|---|---|---|
| | | | |
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| | | | |

***If medications need to be given during the school day, please contact your child's school nurse with questions & to obtain a medication permission form.**

***If at all possible, morning medication should be administered at home prior to the start of the school day.**

***Any first doses of medication (the child has not taken this medication in the past) should be administered at home so that parent/ guardian can monitor closely for side effects.**

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

| Name | Relationship to Student | Cell Phone | Day Phone |
|---|---|---|---|
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| | | | |
| | | | |

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