School Nurse Health Information (Emergency Card)

2022-2023

Student Name / Grade

Parent/Guardian / Relationship / Cell Phone / Other

Street Address / City / Zip Code

Emergency Contact

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

Name of Person	Relationship	Phone

Every school has a nurse assigned to them and staff members trained in CPR. 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 designated emergency contact.

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

By my signature below, I consent for Avoyelles Parish School District (APSD) to provide Non-IEP 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, gender, and my contact information to the Medicaid Agency. I understand that Medicaid reimbursement for Non-IEP services by APSD will not affect any other Medicaid services for which my child is eligible. APSD 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 services.

Parent/Guardian/Student(if 18) Print Name_____

Signature_____ **Date**_____

School Nurse Health Information (Emergency Card)

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

Medication/Medical Procedures : (APSD policy on medications) Any prescription medication or medical procedure(blood sugar check, tube feeding, etc.) to be administered at school or school related activities must be accompanied by written orders from a health care practitioner. NO over-the-counter medications may be administered by the school RN. All information below is confidential for the school nurse and may be shared on a need to know basis for student safety.
Screenings: APSD school nurses conduct vision/hearing/scoliosis screenings and other training based on the LDOE recommendations. Contact your school nurse if you do not want your child to participate.

Please address each yes/no question

Health History:

ADD/ADHD	☐YES ☐NO	☐Takes Medication at Home ☐Needs Medication at School:_____ ADD/ADHD Doctors Name:_____
Allergy	☐YES ☐NO	☐Environmental/Seasonal ☐Needs Medication at School:_____ ☐**Severe(Life Threatening) To:**_____ ☐Has epi-pen or other form ☐Does not have epinephrine for school Last Date Epi-Pen used ___/___/___ Allergy Doctor's Name _____
Asthma	☐YES ☐NO	☐Has rescue inhaler for at school Asthma Doctor's Name:_____
Cardiac (Heart)	☐YES ☐NO	☐Takes medicine at home ☐Needs medicine at School:_____ Heart Doctor's Name:_____
Diabetes	☐YES ☐NO	**SEE SCHOOL NURSE FOR DMMP**
Epilepsy (Seizures)	☐YES ☐NO	☐Takes Medication at Home ☐Needs Medication at School:_____ ☐Has Diastat Last date used___/___/___ Seizure Doctor's Name:_____
Sickle Cell Anemia	☐YES ☐NO	☐Trait ☐Disease ☐Takes medicine at home ☐Needs medicine at School:_____ ☐Last Hospitalization ___/___/___ Doctor's Name:_____
Physical Limitation	☐YES ☐NO	Type:_____ ☐Limitation ☐Assistive Device Required ☐Takes medicine at home ☐Needs medicine at School:_____
Mental Health Consideration	☐YES ☐NO	Type:_____ ☐Takes medicine at home ☐Needs medicine at School:_____
Hearing	☐YES ☐NO	☐Hearing Aids ☐Cochlear Implant ☐Other
Vision	☐YES ☐NO	☐Glasses ☐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