

**MONTGOMERY COUNTY SCHOOL HEALTH UNIT CONSENT FOR SERVICES 2020-21**

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Student's Health Care Provider:** \_\_\_\_\_

The School Health Unit will provide care for all students P-12. This includes, but is not limited to, illness/injury assessment, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes. However, we cannot provide services to your child without this signed consent (except for emergency first aid). The parent/guardian may withdraw/rescind consent at any time in writing. The school also ensures health screenings including height, weight, vision & hearing are completed as required, and legal guardians are notified of any abnormal findings.

**Please review this form carefully, and complete all information requested and return to your child's homeroom teacher or directly to the school nurse.**

All medications sent from home must have proper parent/guardian consent, be in the original container with proper label and taken to the school nurse immediately upon arrival to school for proper storage and administration. Per protocol, non-prescription medications are not for more than three days *consecutively* without a physician's order. **All medications must be provided by the parent/guardian.**

The Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read. To ensure student safety, school health services may share educationally relevant health information with school staff or medical professionals having direct involvement with my child, or may contact the healthcare provider for necessary health information or medication and treatment clarification.

The school nurse (RN) will delegate necessary daily or as needed medication (provided by the parent) for field trips when indicated by school health consent, IHP, parental note or emergency. And that during off campus events, school personnel will make the determination, in case of emergency, to contact 911/EMS for emergency treatment. With all accidents, the student's healthcare coverage is processed first, as the school's accident insurance is a secondary insurance policy.

I understand that a school nurse or trained staff member, in accordance with the Kentucky Department of Education and Montgomery County School Health Protocols, may provide comfort measures such as **saltine crackers, lemon lime caffeine free soda, peppermint disks or soft peppermint** as age appropriate after she/he has evaluated my child's complaint. The health unit also has first aid items, including but not limited to **eye wash/artificial tears, aloe vera gel & Vaseline**.

**Do NOT give my child the listed comfort measures:** \_\_\_\_\_

**Known Allergies:** \_\_\_\_\_

**Known Medical Conditions & Current Medications @ home:** \_\_\_\_\_

My child may require **over-the-counter medication provided by me**, as needed for symptoms of his/her health condition.

**OTC Medication:** \_\_\_\_\_ **Given For:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**OTC Medication:** \_\_\_\_\_ **Given For:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**By signing this consent, I release Montgomery County Schools from any liability related to the administration of medications or treatment as long as reasonable and customary care is given. This consent is given voluntarily and with full knowledge of its significance.**

\_\_\_\_\_  
Parent/Legal Guardian Signature\*

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Date

**Health and Emergency Information Form**

Students Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Grade \_\_\_\_\_ School: \_\_\_\_\_

Legal Home Street Address \_\_\_\_\_

#1 Legal Guardian Name \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_

#2 Legal Guardian Name \_\_\_\_\_ Contact # (\_\_\_\_) \_\_\_\_\_

**Please mark the following CURRENT HEALTH conditions diagnosed by a healthcare provider:**

ADD/ADHD  ANAPHYLAXIS (EPI PEN)  ASTHMA  CARDIAC/ HEART CONDITION  DIABETES

METABOLIC DISORDER  MIGRAINES  SEIZURES OTHER-PLEASE SPECIFY: \_\_\_\_\_

List ALL Medication your child takes at school or at home \_\_\_\_\_

LIST ALL Known Allergies: \_\_\_\_\_

An individualized health plan (IHP) must be completed for all current health conditions. \*A student may not carry a medication (insulin, asthma inhalers, Epi-pens etc) with them UNLESS written permission from their health care provider and parent is provided.

The School Health Unit will provide care for all students. This includes, but is not limited to, illness/injury assessments, medication administration, emergency first aid and/or monitoring/education for chronic disease such as asthma or diabetes and referrals for further medical assessment. The school nurse cannot provide services to your child without this signed consent (except for emergency first aid). The school nurse ensures health screenings are completed including height, weight, vision & hearing as required, and that I will be notified of any abnormal findings.

All medications sent from home must be in the original container, accompanied by proper parent/guardian consent and must be given to the nurse, the staff member designated to provide health services or the supervising teacher/sponsor/coach for proper storage. (Includes field trips) Prescription meds must have written authorization of prescribing healthcare provider and OTC medications must have written approval of parent/guardian. Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available to read.

In order to ensure my child’s safety, school health services may share educationally relevant health information with others having direct involvement with my child. Medication may be delegated by the nurse for field trips when indicated by school health consent, IHP, parental note or emergency situation; based on health information on file in the health unit at the time of departure. By signing below, I give my child consent to participate in **EDUCATIONAL/SPORTS/CLUB** school-related student trip(s). I understand that I am responsible to provide all medications and treatment supplies related to my child’s health conditions indicated above. I authorize trained school personnel to assist my child with his/her medication as my child’s healthcare provider or I have directed if needed. **Teachers/Sponsors are responsible to provide specific information and have specific consent for each trip. Form 09.36 AP.211 is required for any overnight or out of state travel.** School personnel Will make the determination, in the event of accident or sudden illness while at school or on a school-sponsored trip, to have EMS transport my child to the nearest hospital and authorize treatment as deemed necessary for the health of said child.

**EMERGENCY CONTACTS: Please name two (2) persons other than the legal guardian that may take responsibility for your child or make decisions for health care:**

1) \_\_\_\_\_ Phone # \_\_\_\_\_

2) \_\_\_\_\_ Phone # \_\_\_\_\_

Child’s Healthcare Provider: \_\_\_\_\_ Child’s Insurance Provider: \_\_\_\_\_

\_\_\_\_\_  
*Parent/Legal Guardian Signature*

\_\_\_\_\_  
*Date*

Review/Revised:9/26/2017