ORANGEBURG COUNTY SCHOOL DISTRICT ~ NURSING DEPARTMENT

CONFIDENTIAL SCHOOL HEALTH HISTORY/CONSENT FORM School Year: 2020-2021

Last Name: _____ First: _____MI: _____ DOB: _____
Gender: _____ School: _____Teacher:_____ Grade: _____

Mother/Guardian:_____	Father/Guardian:_____
Home#:_____ Work #:_____	Home #:_____Work #:_____
Address: _____	Address: _____
City:_____ Cell #:_____	City:_____ Cell#:_____

Emergency Contact (other than parent): _____ Phone: _____ 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**
***If your answer is yes to any condition, please explain on the back of this form.**

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)
		Medicine		
		Insect sting		
		Food/beverage		
		Requires the use of an Epi-pen or Benadryl for severe allergic reaction (medication will be sent from home).		

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

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 answer is yes to any condition, please explain on the back of this form.

Yes	No		Yes	No		Yes	No	
		ADD/ADHD			Epilepsy/Seizures (see back)			Neurological/brain/spine/CP
		Asthma (see back of form)			Feeding problem/ G-tube			Sickle cell disease
		Cancer			Frequent ear infections			Skin rash/ eczema
		Dental Problem			Frequent headaches			Tuberculosis
		Diabetes			Hearing/wears hearing aids			Urinary (kidney/bladder)
		Difficulty Learning			Heart Murmur/Problem			Vision (glasses/contacts)
		Emotion/behavior problem			High Blood Pressure			Other:

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

I give my permission for my child to receive medical treatment or medication or age appropriate school health screenings as deemed necessary by the school nurse or designated staff. Orangeburg County School District follows the S.C. Department of Health and Environmental Control (DHEC) guidelines, procedures and recommendations for the routine delivery of health services.

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 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), other pertinent health agencies and EMS as needed or when necessary.

I understand that prescription medications may be given at school with a written doctor's order and written parent consent. All medications must be in their original bottle or package and properly labeled from the pharmacy or manufacturer. All medications must be secured in the school nurse's office unless a student has a doctor's note approved for self-medication. A responsible adult must deliver the medication to the school. Controlled medications will be counted with the adult delivering the medication to school.

I understand that (1.) chronic illness or extended medication regimens require individualized health plans to be developed with the parent and school nurse and approved by my child's physician. (2.) "Authorization for Self-Medication or Monitoring" form approved by the doctor and school district is required if a student self-medicates or self-monitors their own medical condition(s). If my child is to self-medicate then the self-medicating board policies must be followed.
I, parent/guardian, will not hold the school, district personnel or Orangeburg County School District liable for the effect of medication upon the student.

Parent/Guardian Signature:_____ Date:_____

FRONT

CONFIDENTIAL SCHOOL HEALTH HISTORY/CONSENT FORM School Year: _____

Does your child ride a school bus? [ ] YES [ ] No (if YES, list the bus number or driver):_____

Does your child take any medications? [ ] Yes [ ] No

Please list any medications that your child takes:

Name of Medication	Dosage/Strength	Time	Doctor who Prescribed

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

***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	

Explain any other medical problem or condition checked on the front of this form: _____

_____

_____

_____

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 phone numbers where you or your emergency contact can be reached in the event of a medical emergency.

When a child's symptom or condition is listed on the South Carolina Department of Health and Environmental Control's School Exclusion List, we are required by DHEC to exclude the child from school until he/she is well. We are asking all parents to keep students out of school if they are sick and to contact their child's doctor.

This includes but is not limited to:

1. **Fever 100 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. **Influenza like Illness- Fever with a sore throat or cough. A student must be fever free without the use of fever reducing medications for at least 48 hours before returning to school.**
3. **Vomiting-** A student must be free from vomiting with illness for at least 24 hours before returning to school or have a doctor's note stating that they can return to school.
4. **Diarrhea-** three or more loose stools in 24 hours.
5. **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 school 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 and call your child's doctor. When a student is ill or injured and needs to be picked up from school, parents are asked to report to the school immediately as soon as possible.

Encourage your child to help us reduce the spread of germs by:

***covering coughs and sneezes * washing hands often *staying away from others who are sick *staying home when sick**

Check your child for head lice often and if found, treat head lice as directed by your physician.
Ask your child not to share hats, scarves, brushes/combs or bows/hair ties with others.

BACK