Student Health Card

Name_____ Teacher_____ Grade_____ Age_____
Date of Birth ____/_____/_____ Address_____
ALLERGIES:_____***(If checked, see school nurse to create an allergy action plan for your child to insure a safe environment for him/her at school.)*
Type of reaction _____
Usual treatment:_____ Epi pen prescribed? _____(If yes, please provide)
HEALTH HISTORY:
ASTHMA_____ *PLEASE PROVIDE MEDICATION FOR SCHOOL* (Inhaler/breathing machine medication)
****(If checked, see school nurse concerning an asthma action plan for your child)*
ADD/ADHD_____ DIABETES_____ SEIZURE DISORDER_____ SICKLE CELL_____
OTHER_____
LIST ANY MEDICATIONS_____
IT IS THE PARENT/GUARDIAN'S RESPONSIBILITY to provide the medication needed for their child's medical condition. Medications provided must be in the original/prescribed container with a medication administration sheet completed.

DOCTOR_____DENTIST_____

I hereby give permission to the Baldwin County School District for my child/ward to participate in the school health program. I understand that I can revoke this permission at any time by written notice to the school health clinic. Treatment in the clinic will include general nursing care.

***Tylenol/Acetaminophen or Motrin/Ibuprofen will ONLY be provided* when a child has a fever of 100.4 or greater. Medications will be given according to age and weight on the original container unless there is documentation of an allergy or if the medication is requested not to be given by his/her parent/guardian.**

*****MEDICATION WILL NOT BE PROVIDED FOR PAIN.*****

****Antacids will be provided to children with an upset stomach or acid indigestion and administered according to guidelines for antacid administration. Parents will be contacted for recurrent stomach problems.

_____ Hearing and Vision Screening *(please check to give permission for screening)*

In case of serious illness/injury, the school will render first aid while contacting the parent. If the illness/injury is considered an emergency the school will call Emergency Medical Services (911) for immediate transportation to Oconee Regional Medical Center. Fees for transportation and services will be the responsibility of the parent or guardian.

This form must be completed, signed and on file in the school clinic before services are rendered.

*SIGNATURE*_____ DATE_____
PARENT OR GUARDIAN

Mother/Guardian_____Home#_____

Work#_____ Cell/Pager#_____

Father/Guardian_____Home#_____

Work#_____ Cell/Pager#_____

IF PARENTS CANNOT BE REACHED, LIST PERSONS WHO WILL ASSUME CARE OF YOUR CHILD

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____