

**Consent for School Health Services  
Allen County Health Department  
CHILD/STUDENT INFORMATION**

School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Team \_\_\_\_\_

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
(Please give child's complete legal name)

Child's Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Race \_\_\_\_\_ Male/Female \_\_\_\_\_ How many people live in the home? \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mother \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Father \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Legal Guardian \_\_\_\_\_ HmPh \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

E-mail address: \_\_\_\_\_

Emergency Contact Person **Other** than guardian or parent \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is your child **eligible** for free or reduced lunch? Yes / No / Don't know

Last School Attended \_\_\_\_\_

**My child HAS the following life threatening condition that requires EMERGENCY treatment or medications to be given at school: Please Circle all that apply.**  
**DIABETES      ASTHMA      SEIZURES      SEVERE ALLERGY      OTHER**

**Child's Medical History:**

1. Significant medical History: \_\_\_\_\_
2. Medications taken on a regular basis \_\_\_\_\_
3. My child has had: Chicken Pox disease: Yes or No    Chicken Pox Vaccine: Yes or No
4. Allergy to MEDICATIONS: \_\_\_\_\_
5. Allergies to: **Peanuts   Bee/Wasp Stings** Explain reactions: \_\_\_\_\_
6. Other: \_\_\_\_\_

**Child's Medical Insurance**

Does your child have a KY Medicaid Card or a KCHIP Card Yes / No Number \_\_\_\_\_

Does your child have other medical insurance Yes / No \_\_\_\_\_

Does your insurance cover immunizations? Yes / No / Don't know \_\_\_\_\_

Child's Health Care Provider \_\_\_\_\_ Child's Dentist \_\_\_\_\_

Does anyone smoke in your child's home? Yes / No \_\_\_\_\_

**Consent for Health Services/Assignment of Benefits**

I consent to care which may include screening, exams, assessments, lab tests, treatment, first aid, over-the-counter medicine, and any other health service given to me/my child by staff of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam on me/my child.

I authorize the school health clinic to release medical/dental information about my child to his/her primary care or dental provider. I also understand that the information obtained for the school physical and immunization information will be released to my child's school. If my child has Medicaid or KCHIP, I also authorize the school clinic to release this information to Medicaid or KCHIP, so that Medicaid or KCHIP can be billed for visits to the school clinic.

I also understand by signing this consent, I acknowledge that I received a copy of the Allen County Health Department's Privacy Notice.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 (Parent/legal guardian/emancipated student) (For school year 2010-2011)

\*\*\*\*\*Please Fill Out Both Sides of this Form and Return to School\*\*\*\*\*  
 \*\*\*\*\*Without written consent, over-the-counter medications cannot be given\*\*\*\*\*

**ALLEN COUNTY SCHOOL HEALTH PROGRAM  
PERMISSION FORM FOR OVER THE COUNTER MEDICATIONS**

Student: \_\_\_\_\_ Student age: \_\_\_\_\_ Date of birth \_\_\_\_\_  
Grade: \_\_\_\_\_ Homeroom/Classroom \_\_\_\_\_

The Allen County School Health Program will provide the following over the counter medications to your child as needed during the current school year. **Please check each medication you approve the school nurse to provide to your child.**

**\*\*\*\*\*Please check the box/boxes of the following medications:\*\*\*\*\***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Benadryl                        | <input type="checkbox"/> Antacid tablets or liquid   | <input type="checkbox"/> No permission given for |
| <input type="checkbox"/> Calamine lotion                 | <input type="checkbox"/> Robitussin (Plain)          | over the counter medication                      |
| <input type="checkbox"/> Ibuprofen                       | <input type="checkbox"/> Hydrocortisone cream (1/2%) |  |
| <input type="checkbox"/> Antifungal cream                | <input type="checkbox"/> Antibiotic ointment         |  |
| <input type="checkbox"/> Throat lozenge, spray, or strip | <input type="checkbox"/> Acetaminophen               |  |
| <input type="checkbox"/> Aloe Vera Lotion                | <input type="checkbox"/> Vaseline Petroleum Jelly    |  |
| <input type="checkbox"/> Sterile Eye Drops               | <input type="checkbox"/> Orajel                      |  |
| <input type="checkbox"/> Saline nose drops               | <input type="checkbox"/> Imodium                     |  |
| <input type="checkbox"/> Hydrogen Peroxide               | <input type="checkbox"/> Claritin                    |  |

**ALLERGIES TO ANY MEDICATIONS OR LATEX:** \_\_\_\_\_

I give permission for (name of child) \_\_\_\_\_ to received the above stated medication at school according to the School Health Services Reference Guide. I release the Allen County Health Department and its employees/Allen County Board of Education and its employees from any claims or liability connected with its reliance on this permission.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Emergency or Cell Phone \_\_\_\_\_  
For school year 2010-2011.

If you child is taking a prescription medication, please contact the school nurse.

**\*\*\*Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.\*\*\***

**\*\*\*\*  Not interested in any services\*\*\*\***

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