SCHOOL NURSE PROGRAM

"Learning Today-Leading Tomorrow!"

Dear Parents/Guardians: The Peach County School Nurse Program will be providing services for your child's school this year.

This form is required each school year to receive services.

It must be completed and placed on file in the school clinic before any services are rendered.

Child's Name: _____ Date of Birth: _____ Gender: M / F Grade: __

Print Parent's name: _____ Phone: Home / Cell _____

EMERGENCY CONTACTS FOR THE SCHOOL HEALTH NURSE: If I can not be reached, school authorities have my permission to contact and release my child to the following 2 individuals if my child becomes ill or is injured.

NAME	RELATIONSHIP	PHONE: HOME / CELL
1. _____	_____	_____
2. _____	_____	_____

HEALTH HISTORY: Please circle all health conditions that apply to your child:

ADHD – Does your child take prescribed medication? YES NO

ASTHMA - Does your child use an inhaler/nebulizer? YES NO

DIABETES – Does your child take oral medication or Insulin injection? YES NO

SICKLE CELL TRAIT OR DISEASE? YES NO

SEIZURES – Does your child take oral medication and/or emergency medication? YES NO

Other Health conditions _____

Allergies: _____

Circle Reaction: Rash/Hives or Trouble Breathing EpiPen Needed? YES / NO

Activity Restrictions/ Please describe: _____

Will your child take doctor prescribed DAILY MEDICATION AT SCHOOL? If yes see your school nurse, you must fill out medication consent form. List medications: _____

Do you have any religious/cultural needs the school nurse should know about? _____

I HEREBY GIVE PERMISSIONS TO THE SCHOOL NURSE AND THE PEACH COUNTY SCHOOL DISTRICT FOR MY CHILD TO PARTICIPATE IN THE FOLLOWING SERVICES OFFERED BY SCHOOL NURSE PROGRAM WHCH I HAVE CHECKED BELOW:

_____ Medication Administration (Tylenol, Ibuprofen, Tums, Benadryl, Cough Drops, Chloraseptic spray)

_____ Wound Care (Antibiotic, Antifungal, Hydrocortisone, Bactine, Caladryl, Vaseline)

_____ Nursing Care and treatment of acute illness

_____ General Primary Nursing Care

I UNDERSTAND AND AGREE THAT IT IS MY RESPOSIBILITY TO NOTIFY THE SCHOOL NURSE OF ANY CHANGES IN THE INFORMATION RECORDED ON THIS FORM. I UNDERSTAND THAT I CAN REVOKE THIS PERMISSION AT ANYTIME BY WRITTEN NOTICE TO THE SCHOOL.

PARENT/ GUARDIAN SIGNATURE: _____ Date: _____