Wayne County School Health Services

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HEALTH INFORMATION (please answer all questions) SCHOOL YEAR: **2019-2020** Grade ________

Name: ____ ☐ M ☐ F Date of Birth:__________________
(Last) (First) (MI)

Local Doctor__________________________ Specialist Doctor______________________ Dentist______________________________

Does student have a ***current*** medical diagnosis of any of the following conditions? Check each item that applies; explain if applicable.

☐ ASTHMA ☐ADD/ADHD ☐WEAR CONTACTS/GLASSES
☐ DIABETES ☐ BLOOD DISORDER ☐HEARING LOSS ☐ RIGHT☐LEFT ☐HEARING AID
☐HEART CONDITION ☐CEREBRAL PALSY ☐ALLERGIC TO MEDICATION (specify): ____________________
☐SEIZURES ☐ KIDNEY DISORDER ☐OTHER (specify): ______________________________________
☐SEVERE OR LIFE-THREATENING ALLERGY TO NUTS, LATEX, OR STINGS (specify): ______________________________

What medication(s) is your child currently taking? ____
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What medication(s) will your child need to take at school (if any) ____
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A parent/legal guardian or other designated adult must bring all medication to the school clinic. At no time may medication be in the reach of children (with the exception of emergency medications as identified in the Wayne County School Medication Procedure). See full policy under health section on school website at www.wayne.k12.ga.us. Please see school nurse to obtain forms if child is to receive medication at school.

I acknowledge that the Wayne County School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

I give my consent for my above named child to participate in vision, hearing, height, weight and dental screenings.

I will notify the school of any change in address, phone number, emergency contact or my child's health status. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. Fees for transport and medical services will be the responsibility of the parent/guardian signed below. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

The Wayne County Schools will not be required to furnish medications but will have the list below on hand as funds are available. Tylenol, Ibuprofen, Maalox, Tums, Benadryl, Oragel, Albuterol Inhaler/Nebulizer, Epi Pen for anaphylactic reactions, saline eye drops; creams such as Benadryl, calamine lotion, hydrocortisone, antifungal and sting kill swabs. Only **2 doses** of these medications will be given per school year before the parents will be required to bring in their own supply for the student.

Date: ___________________ Signature of Parent/Guardian: ____

OPT OUT SIGNATURE ONLY
I DO NOT want my child to receive ANY school health services or medications. I agree to be immediately available to provide care for my child at all times while my child is at school.
Date: ___________________ Signature of Parent/Guardian____