Glascock County Youth Health Services
Medical Consent Form (K-12)

Student Name_____ Grade_____ Teacher_____

DOB_____Doctor_____Phone_____

Who should be contacted first by the School Nurse? Mother ☐ Father ☐ Guardian ☐
Student primarily lives with? Parents ☐ Mother ☐ Father ☐ Guardian ☐ **Does your child have insurance?** Yes ☐ No ☐

Please complete contact information:
Mother:_____ Primary Contact #:_____
Father:_____ Primary Contact #:_____
Guardian:_____ Primary Contact #:_____
Emergency Contact_____ Primary Contact #:_____

Health History – Does your child now have or has he/she ever had:

Asthma	YES/NO	Learning Disability	YES/NO	Physical Education Limitations	YES/NO
Diabetes	YES/NO	Hearing Problems	YES/NO	Food Allergies	YES/NO
Seizure Disorder	YES/NO	Vision Problems	YES/NO	Other illness (list)	
Limitations (list)	YES/NO	Wears glasses/contacts	YES/NO	List Allergies (food, environmental, medications)	

Please explain any **YES** answers. Give as much information that will help your school nurse understand and assist with your child's needs:
_____

_____

Medications taken at home (list) _____

IF YOUR CHILD HAS ASTHMA
Will he/she need to carry his/her inhaler at school? **Yes / No.** If yes, an Asthma Action/Safety Plan will be required (available in the clinic).

IF YOUR CHILD HAS A SEVERE ALLERGY
Will he/she need to carry his/her EpiPen at school? **Yes /No.** If yes, an Emergency Action/Safety Plan will be required (available in the clinic).

STRIKE THROUGH any of the following medications that you DO NOT want your child to have.

Tylenol	Cough Drops	Saline Eye Solution	Sudafed PE
Ibuprofen	Calamine Lotion	Orajel	Tums
Hydrocortisone Cream	Vaseline	Vick's Vapor Rub	Benadryl
Antibiotic Ointment	Children's cough syrup	***Generic preparations may be submitted*	

Please sign ONLY ONE of the following lines:
YES, I give permission for my child to receive free services from the school clinic. This includes, but not limited to hearing, dental, vision, and nutritional screenings. I understand that all services are confidential. I have given accurate and complete information to the best of my knowledge. I realize this permission is in effect until notified in writing otherwise. In the event of a major accident or serious illness, I understand that the school will make every effort to contact me. School clinic personnel have my permission to transport my child to the nearest healthcare facility via emergency medical services if I am unavailable to be reached in the event of an emergency. Fees for transport and medical services will be the responsibility of the parent/guardian signed below. This permission remains in effect from the date of this document through 12th grade, unless revoked in writing. I agree to update this document if healthcare and contact information changes.

Parent/Guardian_____Date_____

NO, I do not want my child to receive non-emergency health services. I agree to be immediately available to provide care for my child at school at ALL times.

Parent/Guardian_____Date_____