ROTC

School Nurse Health Information (Emergency Card)

Student: _____ / _____ / _____ / _____ ☐ MALE ☐ FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

EMERGENCY CONTACT INFORMATION

Parent/Guardian:

_____ / _____ / _____ / _____ / _____
Name Relationship Work Phone Home Phone Cell Phone

_____ / _____ / _____ / _____
Street Address City Zip E-mail

_____ / _____ / _____ / _____
Mailing Address (if different from Street Address) City Zip Occupation

Parent/Guardian (if different from above):

_____ / _____ / _____ / _____ / _____
Name Relationship Work Phone Home Phone Cell Phone

_____ / _____ / _____ / _____
Street Address City Zip E-mail

_____ / _____ / _____ / _____
Mailing Address (if different from Street Address) City Zip Occupation

Please list below three people who have your permission to pick your child up from school and make decisions concerning your child in the event that you cannot be reached.

Name of Person	Relationship	Telephone
1.		
2.		
3.		

Every school is required to have first responders trained in CPR and First Aid. In the event of an emergency, the school staff will contact 911 and follow their instructions. Every attempt will be made to contact a parent, guardian, or designated emergency contact.

Hospital Choice _____ **Doctor's Name** _____ **Doctor's Phone** _____

Insurance/Medicaid # _____

I give the school nurse permission to exchange information with my child's healthcare provider. All information will be kept strictly confidential and used only to provide appropriate individualized healthcare services for my child while in school or school related event.

Parent/Guardian Signature: _____ **Date:** _____

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Student: _____ / _____ / _____ / _____ ☐ MALE ☐ FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

Medication/Medical Procedures: (CCSD policy JLCD-Assisting Students with Medications) Any prescription medication or medical procedure (blood sugar check, tube feeding) to be administered at school or school related activities must be accompanied by written orders from a health care practitioner. Limited over-the-counter medications may be administered by the school RN or LPN with parent consent. Complete consent below. All information below is confidential for the school nurse.

Screenings: CCSD school nurses conduct vision, hearing, blood pressure, BMI and dental screenings, as time permits, based on DHEC recommendations. Contact your school nurse if you do not want your child to participate. Head Start and Early Head Start follow program requirements for vision, blood pressure, BMI, dental, lead and developmental screenings.

Consent	☐YES☐NO	I consent for the Charleston County School District Nursing Services to release and exchange health and personal identification information to Medicaid for billing purposes (if applicable) which will remain confidential and will NOT affect any services my child receives.
Over the counter Medication (OTC)	**Check or Initial Each**	I consent for the Charleston County School District RN or LPN to administer the OTC medication as indicated below. Medication will be administered following the policy JLCD. **__Acetaminophen __Ibuprofen __Hydrocortisone Cream __Anti-fungal cream __Antibiotic Ointment**

Health History: **Please address each yes/no question**

ADD/ADHD	☐YES☐NO	☐Takes Medication at Home ☐Needs Medication at School: ADD/ADHD Doctor's Name:
Allergy	☐YES☐NO	☐Environmental/Seasonal ☐Severe (Life Threatening) to: _____ ☐Takes Medication at Home ☐Needs Medication at School ☐Emergency Medication (Epi-Pen) Last date Epi-Pen used ___/___/_____ Allergy Doctor's Name:
Asthma	☐YES☐NO	☐Daily Maintenance Medication ☐Rescue Inhaler ☐Rescue Nebulizer Asthma Doctor's Name:
Cardiac (Heart)	☐YES☐NO	☐Takes Medication at Home ☐Needs Medication at School: Heart Doctor's Name:
Diabetes	☐YES☐NO	☐Type 1 ☐Type 2 ☐Blood Glucose Checks ☐Oral Medication ☐Carb Counting ☐Takes Insulin ☐Shots ☐Pump ☐Glucagon Diabetes Doctor's Name:
Epilepsy (Seizures)	☐YES☐NO	☐Daily Medication ☐Diastat ☐Other Needs/Treatments ☐Date of Last Seizure ___/___/___ Seizure Doctor's Name:
Sickle Cell Anemia	☐YES☐NO	☐Trait ☐Disease ☐Takes Medication at Home ☐Needs Medication at School ☐Last Hospitalization ___/___/_____ Sickle Cell Doctor's Name:
Physical Limitation	☐YES☐NO	Type _____ ☐Limitation ☐Assistive Device Required ☐Takes Medication at Home ☐Needs Medication at School Disability Doctor's Name:
Mental Health Consideration	☐YES☐NO	Type _____ ☐Takes Medication at Home ☐Needs Medication at School Mental Health Provider's Name:
Hearing Consideration	☐YES☐NO	☐Hearing Aids ☐Cochlear Implant ☐Other
Vision Consideration	☐YES☐NO	☐Glasses ☐Contacts ☐Other
Feeding Consideration	☐YES☐NO	☐Swallowing ☐G-tube feeding at school
Elimination Consideration	☐YES☐NO	☐Diapering ☐Catheterization at school
Other	☐YES☐NO	Describe:

Parent / Guardian Signature_____ **Date** _____