**SCHOOL YEAR: 2020-2021**

CONSENT FORM FOR BATH COUNTY SCHOOL HEALTH UNITS

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

The School Health Units are part of the Bath County School Systems and will offer preventive health care to all students in Bath Co. regardless of income, race, religion, sex, national origin, age, disability, political affiliation or belief. This clinic is on hand to provide all students medicine for minor illnesses and emergency first aid when needed. The Health Units are staffed with caring and professional registered nurses and support staff.

**Please draw a line through any screenings, services, and/or medication that you do NOT wish for your child to receive.** The following basic services are available in the clinics, but they can only be performed with a signature on the back giving consent for services. Please write N/A if question/information does not apply to your child.

\* Assessment for illness. **If we cannot do an assessment of a complaint then we cannot see child or give medication.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Male □Female Race: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name

Address: SSN#

***Write* NAMES and Area Codes *with all phone numbers*. Contact person must also be on student’s pick-up list.**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Name and Phone Number Emergency Contact Name and Phone Number

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone Number Emergency Contact Name and Phone Number

**Please “X” only the medications you want your child to receive for complaints of headache, cough, upset stomach, etc…** These medications will be administered according to current medical recommendations per health unit staff’s discretions after assessment of illness is completed. Generic medications are sometimes substituted. **Medications can only be given a maximum of three (3) consecutive days in a row without a physician’s consent**.

\_\_\_\_ Tylenol (Acetaminophen) \_\_\_\_ Saline Eye Drops/Eye Wash

\_\_\_\_ Advil/Motrin (Ibuprofen) \_\_\_\_ Poison Ivy/Oak Relief (Calamine Lotion)

\_\_\_\_ Stomach/Heartburn Relief (Tums/Rolaids) \_\_\_\_ Skin Itch Relief (Hydrocortisone Cream)

\_\_\_\_ Hard Peppermint Discs \_\_\_\_ Neosporin/Triple Antibiotic Ointment

\_\_\_\_ Cough Drops \_\_\_\_ Burn/Sunburn Relief (Aloe Vera)

\_\_\_\_ Oral Topical Pain Relief (Orajel/Anbesol)

\*\**Students taking prescribed medication must have their medication brought in by a parent or guardian. It should be in a clearly labeled prescription bottle with the* ***SPECIFIC time listed*** *(not just daily, twice a day, etc…) and have on file the completed ADMINISTRATION OF MEDICATION RELEASE form for the prescribed medication. That form is different than this consent.*

Allergies (Food, Stings, Medication, etc…) **EXPLAIN REACTION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*\*Treatment required for **LIFE THREATENING** allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Emergency medications needed for allergic reactions must be prescribed by a doctor. A parent/guardian must bring in these medications and sign an additional form for these to be given. That form is different than this consent.\*\***

Current Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Important medical history we should be aware of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TURN PAGE OVER

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Family Doctor & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Complete:**

Number in household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual Household Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: □Yes □No Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid: □Yes □No ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KCHIP: □ Yes □No ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment for Services/Assignment of Benefits:**

Assignment of Benefits: I request that payment of authorized medical insurance benefits be made to Gateway District Health Department on my behalf for services my child receives. I also authorize the Bath County School Board and the local health department to release medical information about me to Medicaid, insurance and/or other third party payers to determine payment for services. No co-pay will be assessed to your account through the health unit.

**Release of Information and Consent for Services:**

I give permission for Bath County School Health Unit Staff to share pertinent information per professional discretion with other school personnel to promote the personal health, safety, and educational progress of my child. I authorize the school health unit to receive and release medical/dental/eye and immunization information about my child to his/her individual school, primary care doctor, state immunization registry (KYIR), dental provider, or eye care provider as needed or requested. I understand that no guarantees are being made as to the effect of any exam or treatment my child receives. I have also received a Notice of Privacy Practices (HIPAA), which is listed on the school’s website, which describes how medical information about my child may be used and disclosed and how I can get access to this information. I have read this information and have had an opportunity to ask questions. I understand the items as they apply to me. My signature below indicates that I do consent, authorize or declare as stated.

Please read carefully. This consent is for the current school year, and may be withdrawn by the parent/guardian at any time. If you have questions, please contact the health unit at your child’s school. Parental consent is not required for emergency first aid; health counseling; and school health screenings such as scoliosis, height, weight, vision, hearing and head lice.



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Relationship to Child Signature of Parent/Guardian Only Date

**(Stepparent signatures cannot be accepted)**

**\*\*FOR EMERGENCY FOSTER CARE PLACEMENT ONLY\*\***

If a child is placed into EMERGENCY PLACEMENT a Department of Services Representative **must** sign consent for that child.

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**Social Worker Signature and Contact Number Date**

**ONLY the medications listed on this consent may be given. Any other medication(s) will need a separate consent completed and signed by you AND your child’s doctor before it can be administered by the health unit staff. This goes for inhalers (prescription required) and ANY over-the-counter medications not listed.**

**Diabetic students are responsible for bringing in their own diabetic supplies, water, and snacks.**