HVM Health Information for SCHOOL NURSE

Student's Name ________________________________ Date of Birth: __________________________ Grade: _______

PERMISSION FOR MEDICAL TREATMENT, EMERGENCY TRANSPORT, AND MEDICATION ADMINISTRATION AT SCHOOL:
I understand that many, but not all, HVM staff are trained in the basics of first aid and CPR and I authorize them to administer such when appropriate. I also understand that HVM will make every effort to contact me in the event of an emergency requiring medical attention for my child. If I am unable to be reached, I authorize HVM to transfer my child to the nearest medical care facility and/or to _____________________________ Hospital. ______ Parent initials

Child's Doctor: ___________________________ Phone: ______________ Address: ____________________________

Child's Dentist:___________________________ Phone: ______________ Address: ____________________________

Name of Health Insurance Company: ______________________________________ Policy # _____________________

	CIRCLE YES OR NO		
Food or drug allergies?	No	Yes	Describe: ____________________________________
Other allergies?	No	Yes	Describe: ____________________________________
Dietary restrictions?	No	Yes	Describe: ____________________________________
Other health conditions?	No	Yes	Describe: ____________________________________
Mental health concerns?	No	Yes	Describe: ____________________________________
History of concussion?	No	Yes	Date(s)/Describe:______________________________
Asthma or Reactive Airway?	No	Yes	Medications:__________________________________
Seizures or Epilepsy?	No	Yes	Medications:__________________________________
Diabetes?	No	Yes	Medications:__________________________________

Other: ____

My child is currently receiving the following medications **at home**: ____

My child will need the following medication **in school:** ____**

** If your child will need to have medications given at school you **MUST** contact the School Nurse to have the proper plans in place. **ONLY** the School Nurse may administer medication to your child. Please review the Health Policy for further information on Medication Administration at school.

I give permission for my child to receive the medication/s listed below as deemed necessary by the School Nurse for pain, fever, menstrual cramps, itching or treatment of minor cuts. I understand that a generic equivalent medication may be used. I understand the **ONLY the School Nurse,** in accordance with established written protocols, will administer the medication/s I have checked below.

___ Acetaminophen (Tylenol) ___ Ibuprofen (Motrin/Advil) ___ Throat lozenges/cough drops ___Caladryl/calamine lotion
___ Saline Rinse (sensitive or itchy eyes) ___ Hydrocortisone Cream ___ Bacitracin Ointment (Anti-bacterial for minor cuts and abrasions)
___ Benzalkonium Chloride (a wound cleanser that doesn't sting) ___ other _______________ provided by parent with Doctor's orders

I understand I may retrieve my child's medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school. ______ Parent initials

I give permission to have the School Nurse or school personnel designated and trained by the School Nurse to administer the medication, including Epi-pens and inhalers if my child has one in school, during field trips. ______ Parent initials

HIPAA/FERPA Notice Information:

The HIPAA/FERPA privacy regulations limit ways medical information and school records can be shared. Often medical information needs to be shared to support your child's education and safety.

Therefore, we are asking your permission to share Health Care Plans and needed medical information with any HVM staff member or contracted person coming in contact with your child. This information will be released only to persons who have a "need to know" including any emergency services staff that may be needed to transport your child and the treating facility in order provide services or care for your child during school hours.

Parent/Guardian Signature ________________________________ Daytime phone # __________________

Date authorizing exchange of information: ____________________ expires after one year. Rev. 10.2015