Spartanburg School District 7 Student Health Form 2019-2020

Student: _____ DOB: _____ ❑ Male ❑ Female

Grade: _____ Teacher: _____ Medicaid #: _____

Address: _____ Zip Code: _____

Parent/Guardian: _____ H/C #: _____ W #: _____

Parent/Guardian: _____ H/C #: _____ W #: _____

child lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other: _____

List 3 contacts, in case of illness/accident, to pick up your child in the event that you cannot be reached:

Name: _____ H/C #: _____ W #: _____

Name: _____ H/C #: _____ W #: _____

Name: _____ H/C #: _____ W #: _____

Preferred Hospital for emergencies: ❑ Spartanburg Regional Healthcare ❑ SMC Mary Black

I GIVE SPARTANBURG SCHOOL DISTRICT 7 PERMISSION TO GIVE/USE THE FOLLOWING FOR MY CHILD:
*Please indicate using "√". Medication **WILL NOT** be given without written consent of a parent/guardian.*

❑ Yes ❑ No Acetaminophen (Tylenol) for minor pain
❑ Yes ❑ No Ibuprofen (Advil) for minor pain
❑ Yes ❑ No Diphenhydramine (Benadryl) for EMERGENCY use related to allergic reaction only
❑ Yes ❑ No Calcium Antacid (TUMS) for minor stomach discomfort
❑ Yes ❑ No Throat Lozenge/Cough Drop (WITH Menthol) for minor throat pain/irritation
❑ Yes ❑ No Calamine/Caladryl Lotion for minor skin irritations
❑ Yes ❑ No Bacitracin antibiotic ointment for minor cuts and abrasions
❑ Yes ❑ No Benzocaine (Orajel) for minor dental pain

Medical History: *Indicate using a "√" if your child has been diagnosed by a physician for the following:*

❑ ADD/ADHD ❑ Asthma ❑ Bleeding Disorder ❑ Bowel/Bladder Problems ❑ Cancer ❑ Cardiac Condition
❑ Cystic Fibrosis ❑ Diabetes ❑ Epilepsy/Seizures ❑ Hearing Problems ❑ Kidney Disorder
❑ Physical Handicap ❑ Psychiatric/Emotional/Behavioral Conditions ❑ Sickle Cell Disease
❑ Speech Difficulty ❑ Vision Problems (Glasses ❑ Yes ❑ No) ❑ Other: _____

❑ Allergies: _____

If any of the above are selected, please describe: _____

Medications: *Please list ALL medications that your child currently takes:* _____

_____

Will your child be taking medications during school hours? ❑ Yes ❑ No (*If "Yes" please contact school nurse for Medication Administration Authorization Forms)* Name of Medication(s): _____

Telehealth *(applicable for Carver, Mary H. Wright, Cleveland*): Please complete all required forms in order for your child to be evaluated through school telehealth services.

Family Doctor: _____ **Dentist:** _____

I give Spartanburg District Seven permission to share the above information with school administration and staff that have legitimate need. Authorized persons may contact my child's doctor to share or obtain additional information as needed.

In case of an accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to transport my child by ambulance to the hospital listed. I understand that I am responsible for any expenses incurred. ***Your signature below certifies that you have read and understand this form.***

Parent/Guardian Signature: _____ Date: _____