Dawson County Youth Health Services
Consent Form

Student Name__________________________________ Grade_____ Teacher_______________

DOB_______________Doctor______________________________Phone__________________

Who should be contacted first by the School Nurse? **Mother** ☐ **Father** ☐ **Guardian** ☐

Student lives primarily with? **Parents** ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐

Please complete contact information below

Mother______________________________ Primary Contact #:____________________

Father______________________________ Primary Contact #:____________________

Guardian____________________________ Primary Contact #:____________________

Health History – Does you 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)	
Physical 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) ____

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IF YOUR CHILD HAS ASTHMA

Will he/she need to carry his/her inhaler at school? **Yes / No** Where is the inhaler located? **Clinic or On Student?** If yes, an **Asthma Action/Safety Plan** will be required (available in clinic/ on board website).

IF YOUR CHILD HAS A SEVERE ALLERGY

Will he/she need to carry his/her EpiPen at school? **Yes / No** Where is the inhaler located? **Clinic or On Student?** If yes, an **Emergency Action/Safety Plan** will be required (available in clinic/on board website).

Pre-K Only, students will only be administered Tylenol with parent permission. Please circle one: YES or NO

K-12 Only, **STRIKE THROUGH** ANY OF THE FOLLOWING MEDICATIONS THAT YOU **DO NOT** WANT TO BE USED FOR YOUR CHILD

Generic Preparations may be substituted for these listed over the counter products. The Dawson County Schools will not be required to furnish medications but will have these on hand as funds are available

TYLENOL				**SALINE EYE SOLUTION/Visine eye drops**			
Ibuprofen (ages 12+)		**CALAMINE LOTION**		**ORAJEL**		**Chloraseptic Spray**	
***MYLANTA/TUMS**		**HYDROCORT Cream**		**VASELINE/ Vick's Vapor Rub**		***Sudafed PE**	
***BENADRYL liquid/ ointment/ spray**		**antibiotic ointment**		***Children's formula cough suppressant and/or expectorant (guaifenesin and/or Dextromethorphan)**		**Cough drops**	

Does your child have insurance? Yes or NO

In case of emergency, if unable to reach parent/guardian, contact: (listed person will be allowed to pick up my child from school)

Name/Relationship/phone:____

Name/Relationship/phone:____

Please sign ONLY ONE of the following lines:

YES, I give permission for my child to receive free services from the school clinic. 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 for the current school year. ***I agree to update this document annually if healthcare and contact information changes.***

Date_______________ Parent/Guardian signature__________________________________

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

Date_______________ Parent/Guardian signature__________________________________

REV. 3/17