

Given to Parent: IHP _____ (IHP Declined _____) Med Form _____ 504 Letter _____

Date: _____

Student has a: 504 _____ IEP _____

Added to Skyward _____

SUMNER COUNTY SCHOOLS STUDENT HEALTH INFORMATION FORM School Year 2022-23

Dear Parents/Guardians: Please complete the following information, **FRONT & BACK**, and return it as soon as possible. This information will only be shared with the necessary school personnel to maintain and promote the student's health/wellbeing.

Student Name: _____ Sex: Male / Female Date of Birth: _____

School: _____ Grade: _____ Homeroom or 1st Period Teacher: _____

School attended last year: _____

Student is a: Bus rider _____ (Bus number-AM _____ PM _____) Car rider _____ Drives _____ Other _____

Parents/guardians are responsible for providing ALL medications, including over the counter (OTC) medicines, for their children. All medications must be delivered to the school in person by the parent, guardian, or parent/guardian's adult designee.

Check and explain in space below if your child, CURRENTLY or IN THE LAST 2 YEARS ONLY, has had any of the following conditions:

| Disease/Condition | Yes | No | Please explain/elaborate here: |
|--|-----|----|--|
| Diabetes | | | If yes, Type I or Type II? (please circle) Any medications? |
| Heart Problems | | | |
| Significant Kidney or Urinary Problems | | | |
| Asthma (in last 2 years) | | | Is a rescue inhaler used? Y / N Other medications? |
| Psychological Concerns | | | If yes, please list current medications: |
| Stomach/Intestinal Problems | | | |
| Seizure Disorder | | | Type: _____ Date of last seizure: _____ Medications: _____ |
| | | | Is Diastat prescribed? Y / N Has it ever been given? Y / N Date last given: _____ |
| Life-Threatening Allergies | | | To what? _____ |
| | | | Is an EpiPen® prescribed? Y / N Has it ever been used? Y / N Date last used: _____ |
| | | | Is Benadryl given with the EpiPen®? Y / N |
| List All Other Known Allergies (i.e. Meds, Foods, Nuts, Bee Stings, etc.): | | | |
| | | | |
| | | | |
| Other Significant Health Concerns: | | | |
| | | | |
| | | | |

Does your child have a physical or mental impairment that significantly limits one or more major life activities? Y / N If Yes, please explain: _____

Does your child take medication regularly, not listed above? Y / N If Yes, what? _____

Student's primary doctor: _____ Phone: _____

Student's Specialist (if applicable): _____ Phone: _____

Your signature is an informed consent to share health history information with school staff on a need-to-know basis for emergency plans & health plans. Student health information, within the school setting, is limited to the information necessary to serve the student's education and health interests. Your signature gives the school nurse permission to communicate with your student's health care provider(s) regarding health concerns.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Home Phone: _____ Cell: _____ Work/Ext: _____

Parent e-mail address(es): _____

STUDENT'S NAME: _____

**SUMNER COUNTY SCHOOLS
MEDICATION ADMINISTRATION PROTOCOL**

NEVER SEND MEDICINE OF ANY TYPE TO SCHOOL WITH YOUR CHILD. Only medications required to maintain student's attendance will be given. All students must have prescription and non-prescription forms completed before the school can administer medication to the student. **Over the counter/non-prescription medications will be given according to package directions only**, unless accompanied by a physician's order with alternate directions. All prescription medications require physician and parent signature. The pharmacy label **MUST** match the physician's written order. Non-prescription medications require a parent's signature only and must be sent in a sealed, unopened bottle. **No Ziploc baggies, unlabeled bottles, or expired medications will be accepted.**

Please note: alternative medicines and/or treatments such as herbal supplements, homeopathic medicines, vitamins, nutritional supplements, essential oils and any other products that are not regulated by the FDA will not be administered at school. The actions and potential side effects of these products are not readily available to health care providers and will not be given by school staff.

- ◆ Morning & "1-time a day" medications should be given at home. This includes over-the-counter medications such as Advil & Tylenol.
- ◆ Antibiotics ordered **less than 4 times** a day will not be given during school hours.
- ◆ Narcotics will not routinely be given during school hours.
- ◆ A new medication form must be completed **each school year**. This includes insulin and emergency medication orders.
- ◆ Medication guidelines for Sumner County Schools does not allow aspirin or products containing aspirin to be given without a doctor's order (BC Powder, Pamprin, Excedrin Migraine, Bayer Aspirin, Midol, Goody's Powder, Pepto-Bismol, etc.). If you are not certain if a product contains aspirin, please check the list of active ingredients for **"salicylate" or "salicylic acid"** or consult your pharmacist. If these products must be given during school hours, it will require a physician's order.
- ◆ Any changes in medication must be accompanied by a new form, with the changes noted, and signed by the physician. This includes discontinuing a daily medication.
- ◆ All unused medication will only be returned to the parent/guardian/parent's adult designee. If medication is not picked up within two weeks of the request being made, or the medication being discontinued **the medication will be discarded**. No medication will be stored over the summer; **medications left at the end of the school year will be discarded after dismissal on the last full day of instruction.**
- ◆ **No student should ever transport or possess medications on school property, aside from medications permitted by state law & physician order (i.e. EpiPen, rescue inhaler, Glucagon, Cystic Fibrosis enzymes).**
- ◆ **When relocating from another state**, parents will have 30 days to convert existing orders to a Tennessee physician (proof of appointment will also be accepted for specialists and others that may be more difficult to schedule).

I have read and understand the above information and I am aware that my child will not receive medications at school unless my designee or I bring it in. I understand that I will be notified to come to school to sign for any medication that is not brought in correctly.

Parent / Guardian Signature

Date

PARENT/GUARDIAN PLEASE COMPLETE BOTH SIDES OF THIS FORM

Nurse/Staff Notes Only: _____

