School Year: 2023-2024 ICAGEORGIA International Charter Academy of Georgia **Teacher: ________________**

STUDENT HEALTH INFORMATION SHEET

Please ensure that all questions are answered thoroughly.

STUDENT INFORMATION			
Student Name:		Entering Grade:	Date of Birth:
Home Address:			Home Phone #:
Father/Male Guardian Name:		Cell #:	Work #:
Mother/Female Guardian Name:		Cell #:	Work #:
In the event of the parent/guardian cannot be reached, please list at least two other emergency contact people who will be available to pick up your child from school.			
Name:	Relationship	Phone #:	Other phone:
Name:	Relationship	Phone #:	Other phone:

MEDICAL DATA	
Primary Care Provider Name:	Phone #:
Medical Insurance (Company name):	☐ Peach Care ☐ Medicaid ☐ None
MEDICATIONS (List ALL MEDICATIONS taken at home and school *PLEASE NOTE: An additional Medication Permission Form(s) is required for medications to be given at school. For safety reasons, ALL medicine furnished to the school must be in the original container brought in by the parent and not the student.*	

MEDICAL HISTORY: (Check ALL that apply)

☐ Diabetes ☐ Migraines ☐ Frequent Nosebleeds

☐ Athma: is inhaler prescribed? ☐ YES ☐ NO

☐ Seizers: currently on medication? ☐ YES ☐ NO Date of last seizure________________

Describe ____

☐ Heart Issues / Describe: ____

Does your child wear glasses/contacts? ☐ YES ☐ NO Hearing aids? ☐ YES ☐ NO

List OTHER diagnosis, illness, limitations, or disabilities not listed above: ____

Past Hospitalizations/Surgeries ☐ YES ☐ NO If yes, describe ____

Life threatening allergic reactions (anaphylaxis) diagnosed by doctor? ☐ YES ☐ NO If yes, describe ______________________
____

What emergency medication is prescribed? ☐ Benadryl ☐ Epi Pen ☐ Twinject ☐ Other: ______________________________

Seasonal/Food or other allergies ☐ YES ☐ NO If yes, describe ____

In the event of any emergency or accident involving this student and the parent/guardian cannot be reached, I give permission to school authorities to take appropriate emergency action, including calling 911, for transportation to a hospital. I also give permission to the hospital's emergency room staff to treat the student unless I am present and request otherwise. Fees for transportation and medical services will be the responsibility of the parent/guardian.

____ ____

Signature of Parent/Guardian **Date**

School Year: 2023-2024 ICAGEORGIA International Charter Academy of Georgia Teacher: _______________

SCHOOL MEDICATION AUTHORIZATION

***** This form must be completed by all families.*****

Please bring this School Medication Authorization form along with the medication to the school nurse or to the front office.

PLEASE DO NOT SEND IN THE MEDICATIONS AND THE FORM WITH YOUR STUDENT.

PARENT OR LEGAL GUARDIAN AUTHORIZATION (Required for **ALL** Medications) If medications must be given during school hours, this form must be completed. The parent/guardian must provide the school with the over-the-counter or prescription or homeopathic/supplement medication in the original container with unexpired date. Medication will be given as directed on the package or as directed by the below physician. It is the responsibility of the parent/guardian to notify the school of medication changes and complete a new authorization form as needed.

A parent or legal guardian can opt to allow over the counter medications to be applied by the school nurse. The school nurse is able to apply antibiotic ointment such as Neosporin or hydrocortisone cream to any cuts/abrasions or insect bites where applicable. At this time, the school nurse is unable to administer any medications by mouth e.g. Tylenol/Ibuprofen/antacids etc. without the written permission as well as the parent providing the aforementioned medications to be administered by mouth to the school. These medications will be kept in the nurse's office.

___ I give permission to the school nurse to apply antibiotic ointment such as Neosporin or hydrocortisone cream to any cuts/abrasions or insect bites where applicable to my child.

___ I DO NOT give permission to the school nurse to apply antibiotic ointment such as Neosporin or hydrocortisone cream to any cuts/abrasions or insect bites where applicable to my child.

Student’s Name:	Grade:	Birth Date:
Drug allergies/reactions:		
Name of Medication:		
Frequency / Times to be given and dosage:		
Medication for ☐ This School Year ☐ Following Dates Only ________________________		
Physician’s Name:	Phone Number:	

Parent Name Signature Date

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SCHOOL MEDICATION AUTHORIZATION

I, ______________________________________(child's parent/guardian), hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's medication and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance at ICAGA. This authorization expires as of the last day of the school year.

____ ____________________ ___________________________

► Parent/Legal Guardian Signature◄ Date Phone

PHYSICIAN AUTHORIZATION (**Required for Prescription Medications ONLY**)

Name of Medication			
Dosage:	Route:		Frequency/Time to be Given:
Start Medication On:	Stop Medication On:		
Condition/Illness Requiring Medication:			
Common Side Effects of the Medication:			
Physician's Name (Print):		Telephone Number:	
Physician's Signature:		Date:	

School Year: 2023-2024 ICAGEORGIA International Charter Academy of Georgia Teacher: ________________

STUDENT AUTHORIZATION
TO CARRY INHALER, EPINEPHRINE AUTO INJECTOR, INSULIN AND DIABETIC SUPPLIES. OR OTHER APPROVED MEDICATION

*** This form must be completed by all families. ***

Student Name: ___________________________________ Grade: _____ Date of Birth: _________________
(PRINT LEGIBLY)

___ My child needs to carry the inhaler, epinephrine, insulin and/or approved medication. (Continue to the next section).

___ My child **DOES NOT** need to carry the inhaler, epinephrine, insulin and/or approved medication.

I AGREE TO THE FOLLOWING:

- I need to carry the following prescription-labeled inhaler, epinephrine, insulin, and/or approved medication

  ____.
  (PRINT NAME OF MEDICATION LEGIBLY)

- I have been instructed in the proper use of my labeled medication and fully understand how it is administered. I will keep this medication with me and on my person at all times. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription or medication, the privilege of carrying my medication may be reassessed and/or revoked. I also accept the responsibility for notifying the Teachers and/or the School Nurse each time I take my medication.

____ ______________________________
Student Signature **Date**

(We strongly encourage each student to keep a second prescription inhaler, epinephrine, additional Insulin or other prescribed emergency medication in the school clinic in case of emergency and in the event the self-carried medication is lost or left at home.)

To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use this medication at school:

- I accept legal responsibility should the medication be lost, or not immediately available, given, or taken by a person other than the above named student. I understand that if this happens, the privilege of carrying the medication may be reassessed and/or revoked;
- I accept the responsibility to inform the school of all medication changes or new dosages, and will submit a new form to reflect each change;
- Medications must be in their original labeled container and not expired;
- I release International Charter Academy of Georgia and its employees of any legal responsibility when supervising or assisting when the above named student administers his/her own medication;
- Completion of this form authorizes school representatives to discuss this medication order/request with the prescribing provider or emergency healthcare personnel, if indicated or needed.

____ ______________________________
Parent/Guardian Signature **Date**