ICAGEORGIA
International Charter Academy of Georgia

SY2025-2026

Student Health Information Sheet
School Year: 2025–2026

ALL SECTIONS ARE REQUIRED

STUDENT INFORMATION

Student Name:	Entering Grade:	Date of Birth:
Home Address:		Home Phone #:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name 1:	Cell #:	Work #:
Parent/Guardian Name 2:	Cell #:	Work #:

EMERGENCY CONTACTS (OTHER THAN PARENTS)

Name:	Relationship:	Cell #:	Other #:
Name:	Relationship:	Cell #:	Other #:
Name:	Relationship:	Cell #:	Other #:

INSURANCE INFORMATION

Primary Care Provider:	Phone #:
Medical Insurance Provider: ☐ PeachCare ☐ Medicaid ☐ Other: ☐ None	

MEDICAL HISTORY *(PLEASE COMPLETE THOROUGHLY)*

Asthma: Yes ☐ No ☐ *Inhaler prescribed?* Yes ☐ No ☐	Seizures: Yes ☐ No ☐ *Currently on medication?* Yes ☐ No ☐ *Date of last seizure:* _____ *Description:*
Heart Condition: Yes ☐ No ☐ *Description:*	Past Hospitalizations or Surgeries: Yes ☐ No ☐ *Description:*
Diabetes: Yes ☐ No ☐	Migraines: Yes ☐ No ☐
Frequent Nosebleeds: Yes ☐ No ☐	Vision: Wears glasses/contacts? Yes ☐ No ☐
Hearing: Uses hearing aids? Yes ☐ No ☐	Other Diagnoses / Conditions / Limitations *(Include anything not listed above, such as ADHD, autism, etc.)*

ALLERGY INFORMATION

Life-threatening allergies (anaphylaxis diagnosed by a doctor)? Yes ☐ No ☐
Describe: _____
Emergency medication prescribed:
☐ Benadryl ☐ EpiPen ☐ Twinject ☐ Other: _____
Seasonal, food, or other allergies? Yes ☐ No ☐
Describe:

MEDICATIONS TAKEN AT HOME

List all medications taken at home or school (a separate Medication Permission Form is required for school administration). All medications must be in original containers and brought in by a parent.

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OTC TOPICAL TREATMENT PERMISSION

You must select one:
These treatments may include antibiotic ointment (e.g., Neosporin) or hydrocortisone cream for minor cuts, abrasions, or insect bites.

☐ I give permission for the school nurse to apply antibiotic ointment and/or hydrocortisone cream to my child as needed.

☐ I **DO NOT** give permission for the school nurse to apply these topical medications to my child.

EMERGENCY MEDICAL AUTHORIZATION

In the event of an emergency and I cannot be reached, I authorize school staff to take appropriate action, including calling 911 and transporting my child to a hospital. I also authorize emergency room personnel to treat my child unless I am present to state otherwise. I understand that I am responsible for all associated medical and transportation costs.

Parent/Guardian Name (Print): **Signature:** **Date:**

HIPAA Medical Release 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/Guardian Name (Print): **Signature:** **Date:**

School Medication Authorization Form

If your child needs medication during school hours, you must bring both this completed form and the medication directly to the school nurse or front office. **DO NOT SEND MEDICATION OR THIS FORM WITH YOUR STUDENT.**

If your child requires any medication at school

- **All medications must be provided in the original, labeled container with a valid (non-expired) date.**
- **Medications will be administered according to the instructions on the packaging or as directed by the physician listed below.**
- **It is the responsibility of the parent or legal guardian to:**

Notify the school of any medication changes, and submit a new authorization form if changes occur.

SCHOOL MEDICATION AUTHORIZATION (Required for Prescription Medications ONLY)		
Student Name:	Entering Grade:	Date of Birth:
Medication Name:		
Dosage:	Route:	Frequency/Time to be Given:
Start Medication On:	Stop Medication On:	
Condition/Illness Requiring Medication:	Common Side Effects of Medication:	
Physician's Name (Print):	Telephone Number:	

STUDENT AUTHORIZATION TO CARRY INHALER, OTHER APPROVED MEDICATION

To Be Completed by Parent/Guardian:
I give permission for my child to carry and self-administer the following **prescription-labeled** medication at school and during school-sponsored activities (e.g., inhaler, epinephrine auto-injector, insulin):

Medication Name (print clearly):

_____

I confirm the following:

- My child has been instructed in the proper use of this medication and is capable of self-administering it responsibly.
- My child understands **not to share** the medication with others under any circumstances.
- I accept full responsibility if the medication is lost, misused, or taken by someone else.
- I will inform the school of any changes in medication or dosage and provide an updated form.
- All medications will be in their **original, labeled container** and **not expired**.
- I release **International Charter Academy of Georgia** and its employees from any legal liability related to my child's self-administration of this medication.
- I understand that misuse of the medication may result in the privilege being revoked.
- I understand it is strongly recommended that a **backup dose** of the medication be kept in the school clinic in case of loss or emergency.

Student Name (Print): **Grade:**

Parent/Guardian Name (Print): **Signature:** **Date:**