



## Student Health Information Sheet

**\*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: <input type="checkbox"/> PeachCare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: <input type="checkbox"/> None	

### MEDICAL HISTORY (PLEASE COMPLETE THOROUGHLY)

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

### ALLERGY INFORMATION

Life-threatening allergies (anaphylaxis diagnosed by a doctor)? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Describe:</i> _____ <i>Emergency medication prescribed:</i> <input type="checkbox"/> Benadryl <input type="checkbox"/> EpiPen <input type="checkbox"/> Twinject <input type="checkbox"/> Other: _____ Seasonal, food, or other allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Describe:</i> _____
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### MEDICATIONS TAKEN AT HOME

<i>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.</i>
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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.

<b>Student Name (Print):</b>	<b>Grade:</b>
<b>Parent/Guardian Name (Print):</b>	<b>Signature:</b>
	<b>Date:</b>