WILLIAMSON COUNTY SCHOOL HEALTH PARTNERSHIP

Grade in Fall: _____

Student's Name: _____ Sex: _____ Date of Birth: _____

Address: _____ Home Phone: _____
Street City ZIP

Mother/Guardian: _____ Work #: _____ Cell #: _____ Pager #: _____

Father/Guardian: _____ Work #: _____ Cell #: _____ Pager #: _____

Emergency Contact: _____ Phone #: _____ Cell #: _____

Emergency Contact: _____ Phone #: _____ Cell #: _____

Pertinent health information would be used to help your child in case of an emergency:

Health Concerns/Medical Conditions: _____

_____

Medication Allergies: _____ Food Allergies: _____

Medications taken at school: _____

Medications taken at home: _____

CONTINUE INFORMATION ON BACK AS NEEDED

Name of physician: _____ Phone #: _____ Fax #: _____

Name of dentist: _____ Phone #: _____ Fax #: _____

Preferred Hospital: _____ Phone #: _____

The following medications <u>may be</u> available for students. If you wish to give permission for the designated SCHOOL NURSE, <u>when on site</u>, to administer these medications as needed, simply check those you are consenting to and sign the space provided below.

The School Nurse will contact you when the initial dose is administered, or for any other reason that you describe below.

I understand that I can withdraw this consent authorization, at any time, by written document delivered to the staff of the clinic.

Check All that Apply		**I decline all services for my child**
		I give permission for strep testing
		I give permission for the medications indicated below to be administered

Name brand or generic equivalent:	**Tylenol**	**Robitussin DM**	**Benadryl Cream 1%**	**Generic Silvadene 1%**
(Please circle all that might be	**Benadryl**	**Sudafed**	**Antibiotic Ointment**	**Calamine Lotion (Caladryl)**
administered)	**Children's Tylenol**	**Throat Lozenges**	**Hydrocortisone Cream 1%**	**Antacid Tablets and Liquid**
Aleve/Naproxen	**Ibuprofen**	**Cough Drops**	**Topical Anesthetic for gums (Anbesol)**	**Saline Eye Drops**

I authorize my child to receive emergency medical treatment from a medical provider if he/she is seriously injured or ill while in school.

Relevant health information will be shared only as necessary to maintain and promote the student's health and safety.

_____ _____

Parent/Guardian Signature Date

You must return this form in order to participate in the School Health Partnership