IRWIN COUNTY SCHOOLS

School-Based Clinic Permission Form

PLEASE COMPLETE AND RETURN AS SOON AS POSSIBLE. WE MUST HAVE THIS COMPLETED CONSENT FORM IN ORDER FOR YOUR CHILD TO USE THE SCHOOL-BASED HEALTH CLINIC.

Student Name:____Birthdate:_________________Sex: ☐ M ☐ F

School: ☐ IC Pre-K ☐ ICES ☐ ICMS ☐ ICHS Grade:________Homeroom:________________________

Parents or Guardians:____

As the parent/legal guardian of the student named below, I expressly authorize and give permission to the Irwin County School System to have the designated person or persons administer any health service administration to my/our above-named child.

I/We agree that the Irwin County School District and its employees shall not be liable or responsible, and shall be indemnified and held harmless for any illness or damage to any person or property which may result from the storage of medication, from giving out medication, or from failing to give my/our child medication, whether caused by the negligence of the school or its employees otherwise.

In order to provide a safe and healthy environment for your child, this information will be accessible to the following people: school nurse, teachers, and administrators, personnel responsible for health room coverage, and emergency medical personnel.

Medical History: Check any that apply to your child and give details under the comments section.

	ADD/ADHD		Headaches
	Anxiety/Panic Attacks		Hearing Problem
	Asthma		Heart Condition
	Bee Sting Allergy		Kidney/Urinary Problem
	Bowel Problem		Muscle Disorder
	Cerebral Palsy		Neurological Concern
	Diabetes		Seizures
	Color Blindness		Vision Problem
	Epi-Pen		Glasses or Contact Lenses
	Emotional Concerns		PE Activity Limited (Explain below)
	Other (Explain below):		

Comments:____

____

Allergies: List allergies your child has that cause a problem at school.

Name of allergy:_________________________________How long:___________Cause:___________________________

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Medications: Include prescription, over-the-counter, and herbal medication.

Name: Used to treat: Taken at school?

____ ☐ Yes ☐ No

____ ☐ Yes ☐ No

____ ☐ Yes ☐ No

(continued on reverse)

List any other operations, injuries, or hospitalizations and give dates:

____

____

Physician:____Phone:____________________________

Dentist:____Phone:____________________________

Parents:	**Mother**	**Father**
Name		
Home Phone		
Work Phone		
Cell Phone		
Home Address		
City/Zip		

Student lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other (Give information below)

Name:_____________________________________Relationship:___________________________

Home Phone:_______________Work Phone:_______________Cell Phone:________________

IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

Name:_____________________________________Daytime Phone:_________________________

If any information on this form changes it is my responsibility to notify, in writing, the principal or school nurse. If I have any additional instructions or comments, I will make them a part of this record.

I have read this form and understand my responsibility toward the school, which is agreeing to assist me in this matter of health services and medication of my child while at school. I understand I will be made aware of my child's clinic visits and any follow up that may be needed.

I also authorize the prescribing physician named above to discuss with the school nurse, nurse's assistant, principal, or the school's designated staff member any matter regarding the health services and/or medication to be administered and authorizes the prescribing physician to furnish the school with prescription information needed to administer any medication.

I give my consent for my child, _________________________, DOB _______________, to receive medical care at the school-based clinic. I authorize a designated health professional to provide necessary and/or advisable treatment to my child. I give permission for necessary medical tests, procedures, and treatment in the medical evaluation and management of my child's care.

_____________________________________ _____________________________

Signature of Parent/Guardian Date Signed

Daytime phone number of parent signing:______________________________