HEALTH INFORMATION (please answer all questions) SCHOOL YEAR: 2022-2023

Name: _____ ☐ M ☐ F Date of Birth: _____ Grade: _____ Bus Rider: YES NO
(Last) (First) (MI)

What medication(s) is your child currently taking? _____
Medication given at: □ Home (Only) □ School (Only) □ Home & School □ Only in an Emergency

If your child has a medical condition, medication (oral, inhaler, epi-pen, diastat, insulin, etc.) or allergy that requires staff awareness and/or medical attention during the school day, you MUST contact the school nurse to discuss and provide necessary information for implementing and Individualized Health Care Plan.

I I **THIS MUST BE DONE EACH SCHOOL YEAR**

Written permission must be received from the parent/guardian prior to medication administration. Licensed school nurses will supervise administration of medications. All medications will be given according to label instructions and in accordance with OTC school district policy.

Listed below are the over-the-counter medications that our school keeps in stock for administration to students:

- **Acetaminophen/ibuprofen (regular strength). WILL NOT BE GIVEN BEFORE 10:00am OR AFTER 2:00pm ***(may be given for fever over 102 degrees, and headaches or other pains not relieved by other means such as ice, heat, food, fluids, rest, etc.) as deemed necessary and appropriate by licensed nurse.**
- **Antacid (WILL NOT BE GIVEN BEFORE 10:00am OR AFTER 2:00pm**
- **Caladryl**
- **Oral Pain Reliever (Ora-jel)**
- **Diphenhydramine (given in case of allergic reaction)**
- **Antibiotic ointment**
- **Basic 1st Aid Supplies (such as, but not limited to, bactine, peroxide, vionexx antiseptic wipes, sting-kill, etc.)**

If you desire that your child be administered OTC stock medications, after thorough evaluation by the school nurse, please indicate with your signature. If there are any OTC stock meds that your child should NOT receive, contact the school nurse.

Parent/Guardian Signature: _____ Date: _____

The district conducts routine health screenings such as hearing, vision, and scoliosis due to the importance these health factors play in the ability of a student to succeed in school. The intent of the exams or screenings is to detect defects in hearing, vision, or other elements of health that would adversely affect the student's ability to achieve to his/her full potential. Should a student have Arkansas Medicaid, the district will seek reimbursement for vision and hearing screenings. By signing below, your consent grants the school district the ability to release student information for billing Medicaid for vision and hearing screenings for qualifying students.

Do you currently have Arkansas Medicaid? Yes No
Medicaid #:
Do you give consent for Cabot School District to bill Medicaid for reimbursement of mandated screenings? ☐ **YES** ☐ **NO**

Parent/Guardian Signature: _____ Date: _____

I acknowledge that the Cabot School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

I will notify the school of any change in address, phone number, emergency contact or my child's health status. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to provide for the health and safety of my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic. ☐ **YES** ☐ **NO**

Signature of Parent/Guardian: _____ Date: _____