Spartanburg School District 7 Student Health Form 2021–2022 Medicaid

Student: _____ Preferred Name: _____ DOB: _____

☐ Male ☐ Female Grade: _____ Teacher: _____ Primary Language: _____

_____

Address City State Zip

Parent/Guardian	Home/Cell Phone	Work Phone	Lives With
			☐Y ☐N
			☐Y ☐N

List 3 contacts, in the event of illness or emergency, that can pick your child up if you are not available.

Emergency Contact	Home/Cell Phone	Work Phone	Relation
1.			
2.			
3.			

I give Spartanburg School District Seven permission to use the following medications for my child: *Indicate with an "X".*

Medication	Yes, please administer	No, DO NOT administer
Acetaminophen (Tylenol) for minor pain		
Bacitracin Antibiotic Ointment for minor cuts/abrasions		
Benzocaine (Orajel) for minor dental pain		
Calamine/Caladryl Lotion for minor skin irritation		
Calcium Antacid (TUMS) for minor stomach discomfort		
Diphenhydramine (Benadryl) for **EMERGENCY use related to allergic reaction only**		
Ibuprofen (Advil) for minor pain		
Throat Lozenge/Cough Drop **with Menthol** for minor throat pain/irritation		

Medical History:

Please indicate with an 'X" if your child has been diagnosed by a physician with any of the following:

☐ ADD/ADHD ☐ Cardiac Condition ☐ Physical Handicap ☐ Vision Problems
☐ Bleeding Disorder ☐ Cystic Fibrosis ☐ Psychiatric Condition
☐ Bowel/Bladder Problems ☐ Hearing Problems ☐ Sickle Cell Disease
☐ Cancer ☐ Kidney Disorder ☐ Speech Difficulty

☐ Asthma: Does your student have a prescribed Inhaler (Yes or No)? _____
☐ Diabetes: Will your student be receiving Insulin at school via Pen or Pump (Yes or No)? _____
☐ Epilepsy/Seizures: Does your student have prescribed Diastat (Yes or No)? _____
☐ Other: _____

Please list all known Allergies: _____

_____

Does your student have a prescribed Epipen (Yes or No)? _____

Please continue to the back of the form

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Primary Physician	Practice	Phone
Dentist	**Practice**	**Phone**
Specialist	**Practice**	**Phone**

Current Medications

Medication	Purpose	School Administration Needed *Please indicate with an "X"*

Telehealth (applicable for Carver, Mary H. Wright, Cleveland): Please complete all required forms in order for your child to be evaluated through school telehealth services.

I agree to have my student participate in SCDHEC recommended school screenings. _____
Initial

I give Spartanburg District Seven permission to share the above information with school administration and staff that have legitimate need. Authorized persons may contact my child's doctor to share or obtain additional information as needed.

In case of an accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to transport my child by ambulance to the hospital. I understand that I am responsible for any expenses incurred.

Your signature below certifies that you have read and understand this form.

Parent/Guardian Signature: _____ **Date:** _____