Medicaid #_____

Spartanburg School District 7 Student Health Form 2023-2024

Student: _____ Preferred Name: _____ DOB: _____

□Male □Female Grade: ____ Teacher: _____ Primary Language: _____

_____

Address City State Zip

Parent/Guardian (+ Email)	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		
First Aide Burn Cream		

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_____
Other: _____

If your student has been diagnosed with any of the items below, contact must be made with the school nurse ***within the first 5 days of school.***

Asthma: Has your student been prescribed an Inhaler to be used at school (Yes or No)? _____
Diabetes: Will your student be receiving Insulin at school via Pen or Pump (Yes or No)? _____
Epilepsy/Seizures: Has your student been prescribed Diastat to be used at school (Yes or No)? _____
Please list all known Allergies: _____

- Does your student have an Epipen prescribed to be used at school (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"*

District Seven Siblings

Student	**Date of Birth**	**School**

*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 (vision, hearing, dental, blood pressure, and body mass index as applicable). **_____**

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: _____