Peach County Schools

Learning Today-Leading Tomorrow!

SCHOOL NURSE PROGRAM

Dear Parent(s)/Guardian(s):

The Peach County School Nurse Program will be providing services in your child's school this year. It is necessary to complete this form if you would like your child to receive services at their school. Thank you and please let us know if we can help your child in any way or answer any questions.

Child's Name_____ Parent's Name_____

Address_____

Phone Number_____ Parent's Work Number_____

Name of Emergency Contact_____Phone_____

Grade_____ Age_____ Race_____ Gender_____

Date of Birth___/___/___ Doctor's Name/Phone_____

Allergies:_____ If yes, does your child have an Epi Pen ? Yes No

Health Problems:

_____ Asthma -does your child use an inhaler/nebulizer? Yes No

_____ Diabetes -does your child take oral medication or insulin? _____

_____ Sickle Cell- Trait or Disease?

_____ Seizures -does your child take oral medication and/or emergency medication?_____

Other Health Problems:_____

Does your child take medication at school? Name/dosage of Medication:_____

Do you have any religious/cultural needs the school nurse should know about?_____

Please notify the school nurse of any new health problems so that we can help your child with medical questions.

_____

I hereby give permission to the School Nurse and the Peach County School District for my child to participate in the following services offered by the School Nurse Program which I have ***CHECKED*** below. I understand that I can revoke this permission at any time by written notice to the school.

Parent/Guardian Signature_____Date____/___/___

- ☐ Medication Administration (Tylenol, Ibuprofen, Tums, Benadryl, Cough Drops, Chloraseptic Spray)
- ☐ Wound Care (Antibiotic, Antifungal, Hydrocortisone, Bactine, Caladryl, Vaseline)
- ☐ Nursing care & treatment of acute illness
- ☐ General Primary Nursing Care

This form must be completed and placed on file in the clinic before any services are rendered.

Revised March 2014