MODEL LABORATORY SCHOOLS

AT EASTERN KENTUCKY UNIVERSITY

School Health Clinic Consent

PLEASE RETURN TO SCHOOL

Child's Last Name: ______________________________ First Name: ______________________ MI: _____

(***Please give complete legal name***)

Grade: ______________ Homeroom Teacher: ____

Child's Medical History:

Important medical history the Nurse should know about: ______________________________________

____

Medications taken every day (*List name & dosing*): ____

Will medications be taken at school? If so, list (*Name & dosing*): __________________________________

Is your child ALLERGIC to: (*Check only if apply*)

☐ **Medications:** Please LIST: ____

☐ **Peanuts or other NUTS:** EXPLAIN REACTION: ____

☐ **Bee/Wasp Stings:** EXPLAIN REACTION: ____

☐ **OTHER:** EXPLAIN REACTION: ____

Child's Health Care Provider: ________________________ Child's Dentist: ______________________

My child has the following *_life threatening condition_ that may need EMERGENCY TREATMENT or MEDICATION (Epi-Pen, Glucagon, Diastat, Asthma Inhaler, etc.) at school:

☐ **Diabetes** ☐ **Asthma** ☐ **Seizures** ☐ **Severe Allergies** ☐ **Other:** ____________________

***If so, please have Physician/Parent complete Emergency Medication Packet that can be found on Model Laboratory Schools' website.**

Consent for Health Services

I consent to care for my child that may include screening exams, assessments, treatment, first aid, and any other health service given to me/my child by staff of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to receive and release medical/dental information about my child to his/her individual school, primary care or dental provider as needed or requested, including immunization information.

Signature: ____ **Date:** ____________________

(Parent/Legal Guardian/Emancipated Student) ***(Expires in ONE Year)***