TIFT COUNTY SCHOOLS

Student Health Record

Student's Name ______________________ School __________ Grade ______ Date __________

Birthdate __________ Parent/Guardian ______________________________

Address ____

Home Phone # __________ Mother's Work # __________ Cell Phone # __________ Pager # __________

__________ Father's Work # __________ Cell Phone # __________ Pager # __________

Emergency Contact (Is the person on the pick-up list?) ______________________________

Home Phone # __________ Work Phone # __________ Cell Phone # __________ Pager # __________

List brothers/sisters attending Tift County Schools and what school each attends

______________________________ ______________________________

______________________________ ______________________________

Medical History (check all that apply*):

☐ Arthritis	☐ Convulsions w/fever	☐ Migraines
☐ Asthma	☐ Cystic Fibrosis	☐ Missing Organs (eye, kidney)
☐ Bleeding Problems	☐ Dental Problems	☐ Poor Weight Gain
☐ Blood Pressure	☐ Diabetes	☐ Premature Birth
☐ Bowel/Bladder Problem	☐ Fainting Spells/Dizziness	☐ Rheumatic Fever
☐ Breathing Problems	☐ Frequent Headaches	☐ Seizures
☐ Broken Bones	☐ Frequent Nose Bleeds	☐ Speech Difficulty
☐ Bronchitis	☐ Hearing Problems	☐ Surgery/Hospitalization
☐ Chronic/Recurrent Illness	☐ Heart Murmurs	☐ Vision Problems/Contacts
☐ Chest Pain	☐ Heat Exhaustion	☐ Other

*Please explain all checked answers on the back.

Does your child have any potentially life-threatening condition that is not listed above? ☐ Yes ☐ No If yes, please explain:

____

____

Describe how the above checked items affect your child at school.

____

____

Are there any known allergies, including medication, food, and/or environment?

____

What kind of reaction occurs with these allergies?

____

List *all* daily medication, including home and school.

____

Current Physician: __________ Family Pediatrician: __________ Specialist: __________

After School Program: __________

After School Daycare (Name): __________

Car Ride: __________

Bus #: __________

TIFT COUNTY SCHOOLS

Request for Assistive Administration of Medication

This form **must** be properly completed and returned to the school principal/clinic aide, for Tift County School System to assist students in taking their medication during school hours.

- **Tift County Schools does not provide medication for students. Parents are responsible for purchasing and delivering all over-the-counter medications (Tylenol, ibuprofen, Pepto Bismol, Benadryl, etc.) to the school.**
- **The medication will only be given if it is delivered to the principal or clinic aide in the original bottle marked with the student's name, dosage, time of administration, physician, pharmacy, and date of purchase.**
- **Parent/guardian must provide specific instructions, as well as the medication and related equipment.**
- **It is the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.**
- **All medication will be taken directly to the school office or clinic by the parent.**
- **Unused medication will be disposed of unless the parent/guardian picks it up within one week after medication is discontinued, or at the end of the school year.**
- **A new medication request must be provided to the school each school year and with each new medication.**

Name of Student: ______________________________ Birthdate: ____________

School: ______________________________ Grade: ____________

Non-Routine medication that may be needed during the school day (Tylenol, Advil, Aleve): ____________________
Dose ______________

This medication is **NECESSARY** for school attendance.

Prescription Medication to be given at School ______________________________

Date of Prescription: ____________________ Pharmacy used: ____________

Physician's Name: ____________________ Physician's Phone # ____________

Dosage and Time of Administration at school: ______________________________

Discontinue medication on: ______________________________

Allergies: ______________________________

______________________ medication is to be given as needed (Asthma inhaler, Epi-Pen, or insulin). This student has been trained in its use and **may carry this specified medication at all times.**

Illness requiring medication: ______________________________

Possible medication side effects: ______________________________

Other medication the student is taking: ______________________________

Physician's Name and address: ____________________ ____________________

Statement of Parent/Guardian

As parent/guardian of the above named student, I do hereby request the school system to give medication to the above-named student. I understand that the school system is not legally obligated to administer medication to the student. I will notify the school principal and/or clinic aide immediately <u>in writing</u> if the medication is changed. **I understand that if this medication or dosage is changed or discontinued, a new** Request for Assistive Administration of Medication form **must be obtained. I also consent to the sharing of necessary medical information between my child's physician and/or pharmacist and the designated provider of healthcare services in the school setting.** *(If you have read and agree with these terms, sign and date below:*

Parent/Guardian signature: ______________________________ Date: ____________________

****Check here if you would like to schedule an appointment with the Clinic Aide or Nurse Supervisor to discuss your child's medication or medical condition. ☐ Yes ☐ No**