liberty
STEAM Charter School

School Nurse Health Information / Emergency Card

Student: _____ / _____ / _____ / _____ ❑ **MALE** ❑ **FEMALE**
(Last NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

EMERGENCY CONTACT INFORMATION

_____/_____/_____/_____/_____
Name Relationship Work Phone Home Phone Cell Phone

_____/_____/_____/_____
Street Address City Zip E-mail

_____/_____/_____/_____
Mailing Address (if different from Street Address) City Zip Occupation

Parent/Guardian (if different from above):

_____/_____/_____/_____/_____
Name Relationship Work Phone Home Phone Cell Phone

_____/_____/_____/_____
Street Address City Zip E-mail

_____/_____/_____/_____
Mailing Address (if different from Street Address) City Zip Occupation

Please list below three people who have your permission to pick your child up from school and make decisions concerning your child in the event that you cannot be reached.

Name of Person	**Relationship**	**Telephone**
1.		
2.		
3.		
4.		
5.		

Every school is required to have first responders trained in CPR and First Aid. In the event of an emergency, the school staff will contact 911 and follow their instructions. Every attempt will be made to contact a parent, guardian, or designated emergency contact.

Insurance/Medicaid #_____

I give the school nurse permission to exchange information with my child's healthcare provider. All information will be kept strictly confidential and used only to provide appropriate individualized healthcare services for my child while in school or school related events.

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

School Nurse Health Information
(Emergency Card)

Student: _____ / _____ / _____ / _____ ❑ MALE ❑ FEMALE
(LAST NAME) (FIRST NAME) (DATE OF BIRTH) (GRADE/SECTION)

Medication/Medical Procedures: (CCSD policy JLCD-Assisting Students with Medications)
Any prescription medication or medical procedure (blood sugar check, tube feeding) to be administered at school or school related activities must be accompanied by written orders from a health care practitioner. Limited over-the-counter medications may be administered by the school RN or LPN with parent consent**.** Complete consent below. All information below is confidential for the school nurse.

Consents:

Consent for annual vision and hearing	**❑YES❑NO**	**I consent for the annual screenings of hearing and vision to be performed for my scholar. Screenings are typically performed by third party sources here on campus at LSC.**

Consent for Treatment/Release of Information	**❑YES❑NO**	I consent for the LSC Nursing Services to release and exchange health and personal identification information to Medicaid for billing purposes (if applicable) which will remain confidential and will NOT affect any services my child receives.
Over the counter Medication (OTC)	**❑YES❑NO**	I consent for the LSC RN or LPN to administer the OTC medication provided by the parent. Medication will be administered as indicated in the policy JLCD. Name of Medication:_____

Health History:

ADD/ADHD	**❑YES❑NO**	❑Takes Medication at Home ❑Needs Medication at School: ADD/ADHD Doctor's Name:
Allergy	**❑YES❑NO**	❑Environmental/Seasonal ❑Severe (Life Threatening) to: _____ ❑Takes Medication at Home ❑Needs Medication at School ❑Emergency Medication (Epi-Pen) Last date Epi-Pen used ____/____/_____ Allergy Doctor's Name:
Asthma	**❑YES❑NO**	❑Daily Maintenance Medication ❑Rescue Inhaler ❑Rescue Nebulizer Asthma Doctor's Name:
Diabetes	**❑YES❑NO**	❑Type 1 ❑Type 2 ❑Blood Glucose Checks ❑Oral Medication ❑Carb Counting ❑Takes Insulin ❑Shots ❑Pump ❑Glucagon Diabetes Doctor's Name:
Epilepsy (seizures)	**❑YES❑NO**	❑Daily Medication ❑Diastat ❑Other Needs/Treatments ❑Date of Last Seizure ___/___/___ Seizure Doctor's Name:
Mental Health Consideration	**❑YES❑NO**	Type _____ ❑Takes Medication at Home ❑Needs Medication at School Mental Health Provider's Name:
Sickle Cell Anemia	**❑YES❑NO**	❑Trait ❑Disease ❑Takes Medication at Home ❑Needs Medication at School ❑Last Hospitalization ___/___/_____ Sickle Cell Doctor's Name:
Physical Limitation	**❑YES❑NO**	Type _____ ❑Limitation ❑Assistive Device Required ❑Takes Medication at Home ❑Needs Medication at School Disability Doctor's Name:
Hearing Consideration	**❑YES❑NO**	❑Hearing Aids ❑Cochlear Implant ❑Other
Vision Consideration	**❑YES❑NO**	❑Glasses ❑Contacts ❑Other
Other	**❑YES❑NO**	Describe:

Parent / Guardian Signature _____ Date _____