JEFFERSON Sistema escolar del condado

FORMULARIO DE PERMISO DE SERVICIOS DE SALUD ESCOLAR 2023-24

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade\_\_\_\_ trabajada profesor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F de M\_\_\_ \_\_\_School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Tipo de cuidado de la salud: *Check uno:* *Medicaid \_\_\_\_ de PeachCare*\_\_\_\_ *el seguro \_\_\_\_ no el seguro \_\_\_\_\_\_*

**De nombre de la compañía de seguros \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Número de Medicaid de aseguradora de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Historia de la salud de los alumnos (por favor marque todas las que correspondan)**

 ASTHMA  Convulsiones y epilepsia  FIBROSIS quística  Escoliosis

 Problemas de corazón  Problemas de riñon  Sangrado de tendencias  ADD/ADHD

 SICKLE CELL DISEASE  Problemas de estomago  Sangra la nariz FRECUENTE  Depresión

 Dolores de cabeza  Trastornos de la piel  DIABETES  Otro comportamiento

 Otros problemas de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ de problemas MEDICAL LIST

¿Su hijo requiere asientos especiales en el aula? Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

¿Does su hijo llevar gafas audífono/contactos (por favor, haga un círculo)?

¿Su hijo tiene cualquier condición que limite las actividades físicas? List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

¿Por favor, incluya cualquier cirugías o hospitalizaciones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Por favor, incluya cualquier medicamentos que rutinariamente lleva a su hijo y times\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Proveedor de servicios de salud \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone no del niño. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### ALERGIAS

## ¿Su hijo es alérgico a algún medicamento? \_\_\_\_\_ Please List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**¿Tiene su hijo cualquier alergias a los alimentos? \_\_\_\_\_\_ Please List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Su hijo ha tenido una reacción alérgica a cualquier picaduras de abeja/insecto? En caso afirmativo, ¿qué tipo de reacción se produce?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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## ¿Su niño necesitará un Epi-pen en la escuela? ¿Yes\_\_\_\_ No\_\_\_\_ Will su hijo necesita un inhalador en la escuela? Yes\_\_\_ N \_\_\_

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#### INFORMACIÓN DE CONTACTO DE EMERGENCIA

Padre/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teléfono (trabajo) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ de teléfono (particular) de madre/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teléfono (trabajo) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### SI LOS PADRES NO PUEDEN SER ALCANZADOS, UNA LISTA DE DOS PERSONAS CERCANAS A QUIEN DÉ PERMISO PARA ASUMIR CUIDADO DE SU HIJO

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAMENTOS PARA SER DADA POR PERSONAL DE LA ESCUELA:**

**SÓLO del tratamiento medicina ordenó por su niño DOCTOR Y ACETAPMINAPEHN Y IBUPROFENO (como Tylenol y Advil) homologado por padres WILL BE dada durante la escuela dia BY escuela de personal.**

### NO MEDICAMENTOS SERÁN ADMINISTRADOS SIN ESTE PERMISO FIRMADO FORMA DEL PADRE

Me herby conceder el permiso de la escuela para dar tratamiento necesario de menor importancia o medicamentos de venta sin receta a mi hijo. Autorizar a la escuela para discutir y compartir información adecuada y necesaria con otros organismos de salud, médico de atención primaria de mi hijo con el propósito de seguimiento según sea necesario. Yo también conceder el permiso de escuela para llevar salud de rutina de detección (visión, audición, dental, etc.) para mi hijo y notificarme de cualquier resultados anormales.

En caso de enfermedad y lesiones graves, la escuela será proporcionar primeros auxilios y se contactará con los padres. Si ni el padre ni designado puede ser alcanzado y la situación es muy grave, el alumno será transportado a la sala de emergencias más cercana o EMS serán contactados para el transporte inmediato a la sala de emergencias. **Las tarifas de transporte y los servicios médicos estarán a cargo de sus padres o tutores.**

\_\_\_\_ Estoy de acuerdo para que mi niño recibir servicios de salud escolar. Yo le notificará la escuela de cualquier cambio en el estado de salud de mi hijo.

\_\_\_\_ **No** quiero mi niño para recibir servicios de salud escolar.

FIRMA DEL PADRE O TUTOR: \_\_\_\_\_\_­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ DE FECHA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JEFFERSON

COUNTY SCHOOL SYSTEM

SCHOOL HEALTH SERVICES PERMISSION FORM

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade\_\_\_\_ Homeroom Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M\_\_\_ F \_\_\_School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Health Care: Check one: Medicaid \_\_\_\_ PeachCare\_\_\_\_ Insurance\_\_\_\_ No insurance \_\_\_\_\_

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid/Insurance Company Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Health History (Please check all that apply)

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ASTHMA

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SEIZURES/EPILEPSY

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CYSTIC FIBROSIS

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SCOLIOSIS

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HEART PROBLEMS

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KIDNEY PROBLEMS

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BLEEDING TENDENCIES

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ADD/ADHD

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SICKLE CELL DISEASE

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STOMACH PROBLEMS

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FREQUENT NOSE BLEEDS

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DEPRESSION

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HEADACHES

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SKIN DISORDERS

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DIABETES

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OTHER BEHAVIOR

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OTHER MEDICAL PROBLEMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PROBLEMS LIST

Does your child require special seating in the classroom?

Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses/contacts/hearing aid (please circle)?

Does your child have any condition that would limit physical activities?

List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries or hospitalizations?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications your child routinely takes and times\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Healthcare Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES

Is your child allergic to any medications?

\_\_\_\_\_ Please List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any food allergies?

\_\_\_\_\_\_ Please List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had an allergic reaction to any bee/insect stings?

If yes, what type of reaction occurs?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your child need an Epi-pen at school?

Yes\_\_\_\_ No\_\_\_\_ Will your child need an inhaler at school?

Yes\_\_\_ No \_\_\_

EMERGENCY CONTACT INFORMATION

Father/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF PARENTS CANNOT BE REACHED, LIST TWO NEARBY PERSONS TO WHOM YOU GIVE PERMISSION TO ASSUME CARE OF YOUR CHILD

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS TO BE GIVEN BY SCHOOL PERSONNEL:

ONLY PRESCRIPTION MEDICINE ORDERED BY YOUR CHILD’S DOCTOR AND ACETAPMINAPEHN AND IBUPROFEN (like Tylenol and Advil) APPROVED BY PARENTS WILL BE GIVEN DURING THE SCHOOL DAY BY SCHOOL PERSONNEL.

NO MEDICATIONS WILL BE ADMINISTERED WITHOUT THIS SIGNED PERMISSION FORM FROM THE PARENT

I herby grant the school permission to give necessary minor treatment and/or non-prescription medications to my child.

I authorize the school to discuss and share appropriate and necessary information with other health agencies, my child’s primary care physician for the purpose of follow-up as needed.

I also grant the school permission to conduct routine health screening (vision, hearing, dental, etc.) for my child and notify me of any abnormal results.

In case of serious illness/injury, the school will provide first aid and parents will be contacted.

If neither the parent nor designee can be reached and the situation is very serious, the student will be transported to the nearest emergency room and/or EMS will be contacted for immediate transportation to the emergency room.

Fees for transportation and medical services will be the responsibility of the parent or guardian.

\_\_\_\_ I agree for my child to receive school health services.

I will notify the school of any change in my child’s health status.

\_\_\_\_ I DO NOT want my child to receive school health services.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_