Given to Parent: IHP _____ (IHP Declined _____) **Med Form _____ 504 Letter _____** **Date: _______________**

Student has a: 504 _____ IEP _____ **Added to Skyward _____**

SUMNER COUNTY SCHOOLS STUDENT HEALTH INFORMATION FORM

School Year 2023-24

Dear Parents/Guardians: Please complete the following information, **FRONT & BACK**, and return it as soon as possible. This information will only be shared with the necessary school personnel to maintain and promote the student's health/wellbeing.

Student Name: ____ Sex: Male / Female Date of Birth: ______________

School: ______________________________ Grade: __________ Homeroom or 1st Period Teacher: __________________

School attended last year: _____________________________________

Student is a: Bus rider ______ (Bus number-AM ______ PM ______) Car rider ______ Drives ______ Other _________

Parents/guardians are responsible for providing ALL medications, including over the counter (OTC) medicines, for their children. All medications must be delivered to the school in person by the parent, guardian, or parent/guardian's adult designee.

Check and explain in space below if your child, CURRENTLY or **IN THE LAST 2 YEARS ONLY,** has had any of the following conditions:

Disease/Condition	**Yes**	**No**	**Please explain/elaborate here:**
Diabetes			If yes, Type I or Type II? (please circle) Any medications?
Heart Problems			
Significant Kidney or Urinary Problems			
Asthma (**in last 2 years**)			Is a rescue inhaler used? Y / N Other medications?
Psychological Concerns			If yes, please list current medications:
Stomach/Intestinal Problems			
Seizure Disorder			Type: Date of last seizure: Medications:
			Is Diastat prescribed? Y / N Has it ever been given? Y / N Date last given:
Life-Threatening Allergies			To what?
			Is an EpiPen® prescribed? Y / N Has it ever been used? Y / N Date last used:
List All Other Known Allergies (i.e. Meds, Foods, Nuts, Bee Stings, etc.):			
Other Significant Health Concerns:			

Does your child have a physical or mental impairment that significantly limits one or more major life activities? Y / N If Yes, please explain:

____

Does your child take medication regularly, not listed above? Y / N If Yes, what? ______________________________________

Student's primary doctor: ____ Phone: ______________________________________

Student's Specialist (if applicable): ____ Phone: _______________________________________

Your signature is an informed consent to share health history information with school staff on a need-to-know basis for emergency plans & health plans. Student health information, within the school setting, is limited to the information necessary to serve the student's education and health interests. Your signature gives the school nurse permission to communicate with your student's health care provider(s) regarding health concerns.

Parent/Guardian Name: ___________________________________Signature: ____________________________________ Date: _________

Home Phone: ______________________________ Cell: _____________________________ Work/Ext: ______________________________

Parent e-mail address(es)**:**

STUDENT'S NAME: ____

SUMNER COUNTY SCHOOLS MEDICATION ADMINISTRATION PROTOCOL

Protocol in accordance with TN Guidelines for Health Care in a School Setting, T.C.A. § 49-50-1602, T.C.A. § 49-50-1603

NEVER SEND MEDICINE OF ANY TYPE TO SCHOOL WITH YOUR CHILD. Only medications required to maintain student's attendance will be given. All students must have prescription and non-prescription forms completed before the school can administer medication to the student. **Over the counter/non-prescription medications will be given according to package directions only,** unless accompanied by a physician's order with alternate directions. All prescription medications require physician and parent signature. The pharmacy label **MUST** match the physician's written order. Non-prescription medications require a parent's signature only and must be sent in a sealed, unopened bottle. **No Ziploc baggies, unlabeled bottles, or expired medications will be accepted.**

Please note: alternative medicines and/or treatments such as herbal supplements, homeopathic medicines, vitamins, nutritional supplements, essential oils and any other products that are not regulated by the FDA will not be administered at school. The actions and potential side effects of these products are not readily available to health care providers and will not be given by school staff.

- Morning & "1-time a day" medications should be given at home. This includes over-the-counter medications such as Advil & Tylenol.
- Antibiotics ordered **less than 4 times** a day will not be given during school hours.
- Narcotics will not routinely be given during school hours.
- A new medication form must be completed **each school year**. This includes insulin and emergency medication orders.
- Medication guidelines for Sumner County Schools does not allow aspirin or products containing aspirin to be given without a doctor's order (BC Powder, Pamprin, Excedrin Migraine, Bayer Aspirin, Midol, Goody's Powder, Pepto- Bismol, etc.). If you are not certain if a product contains aspirin, please check the list of active ingredients for **"*salicylate*" or "*salicylic acid*"** or consult your pharmacist. If these products must be given during school hours, it will require a physician's order.
- Any changes in medication must be accompanied by a new form, with the changes noted, and signed by the physician. This includes discontinuing a daily medication. All unused medication will only be returned to the parent/guardian/parent's adult designee. If medication is not picked up within two weeks of the request being made, or the medication being discontinued **the medication will be discarded**. No medication will be stored over the summer; **medications left at the end of the school year will be discarded after dismissal on the last full day of instruction.**
- **No student should ever transport or possess medications on school property, aside from medications permitted by state law & physician order (i.e. EpiPen, rescue inhaler, Glucagon, Cystic Fibrosis enzymes).**
- **When relocating from another state,** parents will have 30 days to convert existing orders to a Tennessee physician (proof of appointment will also be accepted for specialists and others that may be more difficult to schedule).

I have read and understand the above information and I am aware that my child will not receive medications at school unless my designee or I bring it in. I understand that I will be notified to come to school to sign for any medication that is not brought in correctly.

____ ________________

Parent / Guardian Signature Date

PARENT/GUARDIAN PLEASE COMPLETE BOTH SIDES OF THIS FORM

Nurse/Staff Notes Only: ____

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2/2023