Dawson County Youth Health Services
Medical Consent Form (K-12)

Student Name_____ Grade_____ Teacher_____
DOB_____Doctor_____Phone_____

Who should be contacted first by the School Nurse? Mother ▢ Father ▢ Guardian ▢
Does the student primarily live with? Parents ▢ Mother ▢ Father ▢ Guardian ▢
Does your child have insurance? Yes ▢ No ▢
Please complete the contact information:
Mother:_____ Primary Contact #:_____
Father:_____ Primary Contact #:_____
Guardian:_____ Primary Contact #:_____

Health History – Does your child now have or has he/she ever had:

Asthma	Yes / No	Learning Disability	Yes / No	Physical Education Limitations	Yes / No
Diabetes	Yes / No	Hearing Problems	Yes / No	Food Allergies	Yes / No
Seizure Disorder	Yes / No	Vision Problems	Yes / No	Other illness (list)	
Physical Limitations (list)	Yes / No	Wears glasses/contacts	Yes / No	**List Allergies** (food, environmental, medications)	

If you answered YES, please explain in as much detail as possible:_____
_____
Medications taken at home (list): _____
_____

If your child has ASTHMA
Will he/she need to carry his/her inhaler at school? **Yes / No** Where is the inhaler located? **The clinic or on Students**?
If yes, an **Asthma Action/Safety Plan** will be required (available in the clinic or on the website).
If your child has a SEVERE ALLERGY
Will he/she need to carry his/her EpiPen at school? **Yes / No** Where is the EpiPen Located? **The clinic or on Student?**
If yes, an **Emergency Action/Safety Plan** will be required (available in the clinic or on the website).

STRIKE THROUGH any of the following medications that you **DO NOT** want your child to have.

TYLENOL		**COUGH DROPS**		**SALINE EYE SOLUTION**		**SUDAFED PE**	
IBUPROFEN		**CALAMINE LOTION**		**ORAJEL**		**BURN CREAM**	
MYLANTA/TUMS		**HYDROCORTISONE CREAM**		**VASELINE/VICK'S VAPOR RUB**		**STING RELIEF**	
BENADRYL (liquid/ointment/ spray)		**ANTIBIOTIC OINTMENT**		***CHILDREN'S COUGH SUPPRESSANT AND/OR EXPECTORANT (Guaifenesin and/or Dextromethorphan)**			

******Generic Preparations** may be substituted. The Dawson County Schools will NOT be required to furnish medications but will have these on hand if funds are available***

In case of emergency, if unable to reach parent/guardian, contact: (the listed person will be allowed to pick up my child from school)
Name/Relationship/phone:_____
Name/Relationship/phone:_____

Please sign ONLY ONE of the following lines:
YES, I give permission for my child to receive free services from the school clinic, including but not limited to hearing, dental, vision, and nutritional screenings. I understand that all services are confidential. I have given accurate and complete information to the best of my knowledge. I realize this permission is in effect until notified in writing otherwise.
In the event of a major accident or serious illness, I understand that the school will make every effort to contact me. School clinic personnel have my permission to transport my child to the nearest Healthcare Facility via Emergency Medical Services if I am unavailable to be reached in the event of an emergency. Fees for transport and medical services will be the responsibility of the Parent/Guardian signed below. This permission remains in effect from the date of this document through 12th grade unless revoked in writing. ***I agree to update this document if healthcare and contact information changes.***

Date_____ Parent/Guardian signature_____

NO, I do not want my child to receive non-emergent health services, and I agree to be immediately available to provide care for my child at school at ALL times.
Parent/Guardian_____Date_____

REV 3/2023