Last School Attended _____

Dreher High School
Richland County School District One

## CONFIDENTIAL HEALTH QUESTIONNAIRE FOR SCHOOL NURSE ONLY

STUDENT NAME_____ BIRTHDATE ____/____/____

MALE ☐ FEMALE ☐ RACE_____ GRADE _____ HOMEROOM TEACHER _____

ADDRESS_____

ZIP CODE_____ HOME PHONE_____

STUDENT LIVES WITH (CIRCLE ONE): MOTHER FATHER BOTH PARENTS OTHER_____

MOTHER/ LEGAL GUARDIAN'S NAME _____EMPLOYER _____

WORK NUMBER_____ CELL PHONE_____ E-MAIL _____

FATHER/ LEGAL GUARDIAN'S NAME _____EMPLOYER _____

WORK NUMBER_____ CELL PHONE_____ E-MAIL _____

STEP PARENT (living with child) NAME _____ PHONE # _____

LIST THE NAME(S) OF ANY SIBLINGS AT PRESENT SCHOOL: _____

HEALTH CARE PROVIDER/NURSE PRACTITIONER_____

TELEPHONE NUMBER_____ LAST PHYSICAL/VISIT _____

DENTAL CARE PROVIDER_____

TELEPHONE NUMBER _____ LAST VISIT _____ (RECOMMENDED CLEANING EVERY 6 MONTHS)

MEDICAID (CIRCLE ONE) Y / N POLICY NUMBER_____

PREFERRED HOSPITAL_____

**LIST 2 AUTHORIZED PEOPLE TO ASSUME RESPONSIBILITY AND PICK UP YOUR CHILD IN CASE OF AN ILLNESS/EMERGENCY WHEN THE PARENT/GUARDIAN CANNOT BE REACHED**

1. NAME _____RELATIONSHIP TO STUDENT _____
   PHONE NUMBER (WORK)_____(HOME)_____ (CELL)_____
   ADDRESS_____

2. NAME _____RELATIONSHIP TO STUDENT _____
   PHONE NUMBER (WORK)_____(HOME)_____ (CELL)_____
   ADDRESS_____

(PLEASE COMPLETE THE BACK OF THIS FORM) OVER



Reviewed By: _____ Date: _____ School Year: _____

| **Permission for School Administration of Prescription Medication**<br>**Richland County School District One**<br>**School Year:** _____ | For school use only:<br>❑ Routine<br>❑ PRN (As needed)<br>Start Date:_____ |
|---|---|

When possible, medications should be administered by the parent/guardian before or after school hours. The first dose of any medication that your child has not taken before will not be given during school hours. Prior to your child receiving any prescribed medications during the school day, this form must be completed with prescribing physician's signature and the signature of the parent/guardian for each medication. In order for the school nurse to comply with the medication order, the medication must be in its original labeled container by the pharmacy. If you receive "Sample" medications from your health care provider, the sample medications must be in a container that appropriately identifies the medication and your child.

**By signing this form, the parent/guardian and health care practitioner acknowledge that information from this form may be included in the student's Individual Health Care Plan, if applicable.**

Child's Name _____ Date of Birth _____

Name of School Child Attends _____ Grade _____

**Is child allergic to any food, medicines, or other items? ❑ No ❑ Yes (List allergies.)**

| Medication: | | Medical Diagnosis: | ICD-10 Code: |
|---|---|---|---|
| Dosage: | Route: | Frequency: (e.g., daily) | Time medication to be given at school: |
| Anticipated number of days medication will be given at school:<br>❑ until end of the current school year<br>❑ _____weeks<br>❑ _____days<br>❑ until end of Summer School for the current school year | | Special storage requirements:<br>❑ None ❑ Refrigerate ❑ Other (please specify)<br>Is this medication a controlled substance?<br>❑ No ❑ Yes | |
| Possible Side Effects: | | | |

**Prescribing Health Care Practitioner's Signature** _____ **Date** _____

| Stamp, Print or Type Health Care Practitioner's Name, and Address: | Office Telephone Number<br>Office Fax Number |
|---|---|

**The following section is to be completed by child's parent or guardian.**

I give permission for my child _____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the healthcare practitioner named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the healthcare practitioner named above, the pharmacist and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I also give permission for this form to apply if I transfer my child to another school in Richland County School District One during the current school year and Summer School. I will not hold the school, school district or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed method. I agree to notify the school if my child's medication changes or changes with my contact information.

Signature of Parent/Guardian _____ Date _____

Print or Type Name of Parent/Guardian _____ Day Telephone Number _____

# Permission for School Administration of Non-Prescription Medication

School District: Richland School District One

**School Year** _____

For school use only:
- ☐ Routine
- ☐ PRN (As needed)

Start Date: _____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Grade

Is your child allergic to any food, medicines, or other items? ☐ No ☐ Yes (If yes, list allergies.)

Name of medication to be given at school:

Reason for medication:

| Amount of medication to be given: | Time of day medication to be given at school: |
|---|---|
| Note any special storage requirements:<br>☐ Refrigerate ☐ Other (please specify) | Estimated number of days medication will be given at school (choose one):<br>☐ _____ days ☐ _____ weeks<br>☐ until the end of the current school year<br>☐ until the end of Summer School for the current school year |

Does your child take any other medications at home or at school? ☐ No ☐ Yes (If yes, what are the medications?)

| Child's Health Care Provider's Name and Address (please print ): | Office Phone Number: |
|---|---|
| | Office Fax Number: |

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if any of my child's medications change and/or changes to my contact information.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print or Type Name of Parent / Guardian Day Phone Number

RICHLAND ONE

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# CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AND FOR MEDICAID REIMBURSEMENT

**PURPOSE:** *This is an updated Medicaid Form that asks for your consent to share necessary information to verify Medicaid eligibility and to bill for school-based Medicaid reimbursement with Richland County School District One. When the district verifies Medicaid eligibility or bills for school-based services based on your child's eligibility for public benefits, it **DOES NOT** affect or impact health insurance or other Medicaid covered services that are provided to your child or family outside of school. **Please review, sign and return to school with your child within three days of receipt of this form.***

Richland County School District One (the District) and the South Carolina Department of Education have my permission to provide health-related services to my child and to release and exchange medical, psychological, and other personal identifiable confidential information, as necessary, to the Department of Health and Human Services and any third party insurance carrier regarding health-related services provided to my child. I understand that the purpose of this consent is to bill Medicaid or other health insurance for services under Part B of the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the South Carolina Department of Education my permission to bill Medicaid and any third party insurance and receive payment from Medicaid or any third party insurer for health-related services set forth in my child's individualized education program (IEP), and for psychological evaluation services, nursing services, and other health-related treatment services billable to Medicaid without the requirement of an IEP. I understand that the District and the South Carolina Department of Education have provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to accessing Medicaid or any third party insurance benefits and prior to this consent for release of information to bill Medicaid.

I further understand that the District and the South Carolina Department of Education will provide me annual written notification of my rights before Medicaid accesses my child's benefits to pay for services under the IDEA and that this consent for release of information to bill Medicaid is a one-time consent and is not required annually thereafter regardless of whether there is a change in the type or amount of services to be provided to the child or a change in the cost of the services to be charged to Medicaid or a third party insurance.

I understand that Medicaid reimbursement for health-related services provided by the District and the South Carolina Department of Education will not affect any other Medicaid services for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether I enroll my child in public or private benefits or insurance programs. I also understand that my refusal to allow access to the Department of Health and Human Services or any third party insurance carrier does not relieve the District of its responsibility to ensure that all required services are provided at no cost to me.

I understand that the granting of consent is voluntary on my part and may be revoked at anytime.
If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

I also understand that the District and the South Carolina Department of Education will operate under the guidelines of Part B of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of health-related services.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Medicaid # Social Security #

_____ _____

Signature of Parent/Guardian Date

WHITE – Student's Health Folder YELLOW – Medicaid Quality Assurance Monitor