ANDERSON COUNTY
HEALTH DEPARTMENT

Consent for School Health
CHILD / STUDENT INFORMATION

Please Return to School Services

Teacher____**Grade**_____________ Team____________________

Child's Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Child's Last Name______________________________**First Name**___________________________**MI**______
(Please give CHILD'S complete legal name)

Birth Date_____________________________

Race___________ Male / Female How many people live in the home? ________________

Street Address___________________________________ City______________________

Zip_________________

Mother _______________________________Hm Ph____________Wk Ph____________Cell Ph_____________

Father _______________________________Hm Ph____________Wk Ph____________Cell Ph_____________

Legal Guardian _________________________Hm Ph___________Wk Ph____________Cell Ph_____________

Emergency Contact Person **OTHER** than guardian or parent____

Home Phone______________________Cell Phone____________________Work Phone ____________________

Is your child **ELIGIBLE** for free or reduced lunch? Yes / No / don't know

Last School Attended____

My child **HAS** the following **LIFE THREATENING** condition that requires **EMERGENCY TREATMENT** or **MEDICATION TO BE GIVEN AT SCHOOL…** **DIABETES** **ASTHMA** **SEIZURES** **SEVERE ALLERGY THAT REQUIRES EPI-PEN** **OTHER**__________________

CHILD'S Medical History
1) **Significant medical history**: ____
2) **Medications** taken on a **regular basis**____
3) My child has had: Chicken pox **disease**: Yes / No Chicken pox **vaccination**: Yes / No
4) **ALLERGIES to MEDICATIONS:** ____
5) **ALLERGIES to FOODS:** ____
6.) **ENVIRONMENTAL/OTHER ALLERGIES**:____

Child's Medical Insurance
Does your child have a KY **Medicaid** Card Yes / No **Number (REQUIRED)** ________________________
Does your child have a **KCHIP** Card Yes / No **Number (REQUIRED)** ________________________
Does your child have **health insurance** Yes/ No **Company/policy#** ___________________________
Does it cover Immunizations/Physicals? Yes / No / Don't know

Child's Primary Care Physician____________________________Child's Dentist__________________________

Does anyone smoke in your child's home? Yes / No

Consent for Health Services/Assignment of Benefits

I consent to care which may include screenings, exams/physicals, assessments, lab tests, treatment, first aid, over-the-counter medicine, and any other health service given to me/my child by staff of this school health clinic site. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child. I authorize the school health clinic to release medical /dental information about my child to his/her primary care or dental provider. I also understand that the information obtained for the school physical, including immunization information, will be released to my child's school. If my child has Medicaid or KCHIP, I also authorize the school clinic to release this information to Medicaid/KCHIP so that the Medicaid/KCHIP can be billed for visits to the school clinic. I acknowledge the Anderson County Health Department's Privacy Notice, and will be provided with a copy of this notice if requested.

Signature:______________________________ **Date**:_________________________
(Parent /legal guardian /emancipated student) (*EXPIRES ONE YEAR AFTER DATE SIGNED)* ACHD 2
(6/15)