TIMBERLAKE PUBLIC SCHOOLS
STUDENT HEALTH HISTORY

Name of Student:______________________________ Birth Date: ______________________

Male or Female (circle one) Grade: ________

	Yes	No		Yes	No
ADD/ADHD			Dental Problems		
Allergies to food or insects			Diabetes Type I or II		
Anxiety/Depression			Has an Epi Pen for allergic reactions		
Asthma-uses an inhaler			Hearing or Speech Problems		
Autism/Asperger Syndrome			Heart Condition		
Bladder/Bowel problems			Seizures		
Bleeding Disorders			Stomach Problems		
Cancer			Vision issues: wears contacts, glasses, or has cataracts		
Cerebral Palsy			Other issues:		

If the answer to any of the above is YES, especially allergies, please tell us more: ___________

____

Does your child wear a hearing aid? Yes or No (please circle one)
Does your child have any special health care needs? Yes or No (please circle one)
If Yes, please explain: ____
What MEDICATIONS does your child take regularly:___________________________________
What Medications will your child take at school:_____________________________________
Students requiring any Over The Counter (OTC) or Prescription medication at school MUST have a current school year **Medication Consent** on file. Physician authorization is required for any prescription medication to be given at school. Please contact the school for a **Medication Consent** form.
Are there any other medical problems that you would like to share?:

____

*I give permission for my child to be screened by the school nurse or other designated screening personnel for hearing, vision, scoliosis, height, weight, blood pressure, pulse, and dental problems.
YES **NO**
*I give permission for hydrocortisone, antibiotic ointment, Tums, Motrin, Tylenol to be used on my child as deemed necessary by the school nurse/designated staff for first aide purposes.
YES **NO**
*I give consent for the school nurse/school personnel to look up my child's immunization record on the OSIIS website. **YES** **NO**

Name of child's physician: ___________________________________ Phone: _______________
Parent/Guardian Signature: __________________________________ Date: _______________
Parent/Guardian phone number: ____

MEDICAL STATEMENT

Requesting Special Foods in Child Nutrition Programs

Part I (to be filled out by SFA or Parent/Guardian)

Name of Student: ______________________ Age: ______________________

Name of Parent/Guardian: ______________________ Telephone Number: ______________________

School District: ______________________ School Attended by Student: ______________________

Part II (to be filled out by a recognized Medical Authority)

Diagnosis (include description of the patient's medical or other special dietary needs that restrict the child's diet):

____

____

____

List food(s) to be omitted from diet:

____

____

____

List food(s) that may be substituted (diet plan):

____

____

____

Additional information:

____

____

____

______________________ Date

______________________ Signature of Recognized Medical Authority

______________________ Medical Authority Telephone Number

TIMBERLAKE PUBLIC SCHOOLS
CONTRACT FOR EXCEPTION:
TO SELF-ADMINISTER AND RETAIN MEDICATION ON PERSON

*Provisions under 70 O.S. 1984, Section 1-116.3 and the Timberlake Public School allow a student to self administer a prescribed asthma, anaphylactic medication or diabetic medication. Approval to self administer medications must be authorized by the prescribing physician. The parent/guardian of the student is to *provide the school an emergency supply of the student's medication.*

____I have instructed __________________________________, in the proper use of his/her medication and it is my professional opinion that this student is capable of self-administration of the medication and should be allowed to carry and use that medication by himself/herself.

____ ____________________

Physician signature Date

I understand this request is governed by Timberlake Public Schools regulations on self-administration of medication and there are conditions and exceptions to self-administration. I have instructed my child to inform school personnel if symptoms persist so additional emergency care can be obtained, if needed. I also understand that this permission may be revoked if my child misuses the medication. I understand that Timberlake Public Schools, its agents and employees shall incur no liability for any adverse reaction or injury suffered by this student as a result of self-administration.

We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication.

____ ____________________

Signature of Legal Parent/Guardian Date

This form is valid for the current school year. A new form is required yearly

TIMBERLAKE PUBLIC SCHOOLS
CONSENT FOR PRESCRIPTION MEDICINE

(Please fill out a separate form for each medication needed)

I have read the regulations for medication administration and I hereby request and authorize the Timberlake Public School nurse/designated employee to administer the following medication as directed. I agree to release, indemnify, and hold harmless Timberlake Public Schools and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering this medication to this student. **I understand that permission is granted for the exchange of verbal and/or written communication between the school nurse and the prescribing physician regarding this medication.**

*****Medications must be picked up by the parent or designated adult at the end of the year. Any medications not picked up will be destroyed*****

Parent/Guardian Signature:____

Printed Name of above:____

Date:____________________

TO BE COMPLETED BY THE PHYSICIAN:

PRESCRIPTION MEDICATION

Student:_________________________ DOB:____________ Grade/Teacher:______________

Diagnosis:____

Medication:_________________________ Dosage:____________________

Times to be given at school:____

Special Instructions:____

Physician Signature:____

Date:____________________

This form is only valid for the current school year. A new form is required yearly.

MAY RETURN WITH PARENT OR FAX BACK TO : 580-626-4414

Timberlake Public Schools
Medication Regulations

If it is necessary that a medication be given during school hours the following regulations must be met:

*Prescription Medication must be ordered by a physician/dentist and permission granted for the school staff to contact the prescribing physician/dentist if necessary regarding this medication.

*Prescription medication must be brought to school in the **MOST RECENT**, **ORIGINAL** container with appropriate label intact. The label must have the student's name, name of medication, dosage, and time to be given. **IF MEDICATION IS NOT PROPERLY LABELED, IT WILL NOT BE GIVEN.**

*The parent/guardian will promptly notify the school of any change in the administration of prescription medication and will provide the school with new prescription bottle and physician order. Verbal and written changes from parent/guardian **CANNOT** be accepted.

*The parent/guardian will notify the school of any physician change and obtain a new written prescription.

*All medication to be given at school must be kept in the nurse's/administration's office, regardless of age. Exceptions are made for asthma inhalers or medication for life-threatening conditions, which may be carried by a student **AFTER** the school receives the appropriate signed consent form. School personnel shall not be responsible for any adverse reaction suffered by the student as a result of self-medication.

*Non-prescription medication must be in the **ORIGINAL** container. The dosage and time will be followed according to manufacture instructions and recommendations.

*Medication cannot and will not be accepted in baggies or envelopes.

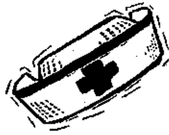
*Parent/guardian **MUST** sign the consent form, granting designated school nurse/employee permission to give the medication during school or during school-sponsored activities, according to school policy.

*For your child's safety, the parent/guardian must bring prescription/non-prescription medication to the school, rather than sending it with the student. At the end of the school year, any remaining medication must be picked up by the parent/guardian or it will be discarded by the school. The school cannot send medications home with students. The only exceptions are emergency medications such as rescue inhalers, epi-pens and insulin. These medications must have a medication consent form on file, signed by a parent/guardian and a physician, stating the student can carry the medications. It is highly suggested that you provide a back-up medication to the office.

*The parent/guardian agrees to provide medication and any particulars connected with administering medication at their own expense.

Student Name:______________________________________

Parent/Guardian
Signature:____Date:________________



When to keep your child home from school. . .

If your child wakes up not feeling well, please use the following as guidelines for keeping him/her home from school.

*Temperature of 100 degrees or greater and then 24 hours after the temperature returns to normal <u>without fever-reducing medications.</u>

*Timberlake highly recommends that any student experiencing symptoms consistent with Covid-19 be tested prior to returning to school. This includes a temperature of at least 100 degrees.

*Vomiting and/or diarrhea during the past 24 hours.

*An unidentified rash. Children with an unidentified rash may not attend school until the rash is gone or it is diagnosed as non-contagious by a physician and a doctor's note obtained.

*Communicable diseases as listed in the Communicable Disease Policy.

Please make sure the office has current phone numbers to reach you. It may be necessary to get ahold of you in the event that your child becomes ill during the day.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ("PHI")

Patient Name:_______________________________ Medical Record #:___________________________

Date of Birth:_________________________________ Social Security #:___________________________

I hereby authorize the **Oklahoma State Department of Health ("OSDH")** to release the following information to:

____;
Name and Address of School or Organization

and ____.
Name and Address of Alternative School or Organization

Information to be shared:

Medical information relating to a positive confirmation of the novel coronavirus (SARS-CoV-2 or COVID-19) in the patient named above.

The information may be disclosed for the following purpose(s) only:

To notify the school that the patient attends in order for the school and OSDH to take measures that prevent the further spread of the coronavirus.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of the PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect the eligibility for benefits, treatment, enrollment or payment of claims.
- The medical information may indicate that the patient has a communicable and/or non-communicable disease which may include, but is not limited to diseases such as the novel coronavirus, hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing the PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____________________________________

____

_____________________________________ _____________________________________
Signature of Patient or Legal Representative Date

_____________________________________ _____________________________________
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)