LEXINGTON-FAYETTE COUNTY HEALTH DEPARTMENT (LFCHD) SCHOOL HEALTH SERVICES

650 Newtown Pike
Lexington, KY 40508
(859) 288-2314 PHONE
(859) 288-2313 FAX

Student Health Consent Form

Please complete one form per student

CONSENT FOR STUDENT HEALTH SERVICES

All students will receive basic first aid and emergency care. By signing this form, I consent to school health services, including, but not limited to, the application of anti-itch ointment, antiseptic cleaner, and/or eye wash, being given to my student by nurses or agents of LFCHD while at school. If my student requires emergency medical assistance which cannot be provided on-site by a school nurse and I cannot be reached, I consent to LFCHD arranging for the provision of emergency medical care for my student, including, but not limited to, transportation of my student to the nearest health care facility and/or to secure necessary medical care for my student at that facility.

If I or my student participates in Kentucky Medicaid or K-CHIP, I authorize LFCHD to release my student's medical information to Medicaid/K-CHIP so that Medicaid/K-CHIP can be billed for services provided by the school nurse, at no cost to me.

I understand that, by signing this consent, I acknowledge that I received or have access to a copy of LFCHD's Notice of Privacy Practices located at www.lexingtonhealthdepartment.org or I may request a copy by calling the School Health Services Division at 859-288-2314.

X_____ ____/____/____

(Signature of Parent / Legal Guardian / Emancipated Student) *(Date signed)*

CONSENT FOR RECEIPT AND DISCLOSURE OF STUDENT MEDICAL INFORMATION

I hereby consent to LFCHD releasing medical information about my student to his/her Primary Health Care Provider or other Health Care Provider as necessary for purposes of treatment.

I hereby consent to LFCHD accessing the Kentucky Immunization Registry (KYIR) and obtaining the immunization status for all immunizations required for attendance at a Kentucky public school. I further consent to LFCHD providing copies of those immunization records, or the information contained therein, to the Fayette County Public Schools (FCPS). The purpose of this record or information retrieval and disclosure is to verify that my student has received the required immunizations for attendance under Kentucky law. I further consent to LFCHD sharing the same records or information with the Kentucky Cabinet for Health and Family Services (CHFS) and its divisions, subparts and/or employees for the purposes of compiling statistical data, to help control, abate and/or otherwise affect the spread of infectious disease, and/or as otherwise required by law. I further consent to LFCHD entering my student's immunization information into KYIR.

This consent form will remain in effect for your student through graduation, departure and/or other termination of enrollment from a FCPS school, unless you revoke this consent in writing at any time, except any such revocation will not affect information that has already been released in reliance upon this consent.

Any information released in response to this consent may be re-disclosed to other parties.

No medical treatment or payment is conditioned on the signing of this consent.

You have a right to receive a copy of this consent form.

Any facsimile, copy or photocopy of this consent shall authorize the release of student medical information as limited to and described herein.

X_____ ____/____/____

(Signature of Parent / Legal Guardian / Emancipated Student) *(Date signed)*

Please return form to School Nurse

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Student Health Information Form

Please complete one form per student

Last Name:_____ **First Name:**_____ **MI:**_____

Student's Social Security # _____ **Birthdate:**_____

Race (check one or more): ____Caucasian/White ____African American/Black ____Native American/American Indian or Alaska Native ____Asian ____Native Hawaiian or other Pacific Islander

Ethnicity: Hispanic or Latino ____Yes ____No **Sex:** ____Male ____Female

Street Address_____ City_____ State_____ Zip _____

Parent/Legal Guardian _____ Primary Number _____ Alt Number _____
Parent/Legal Guardian _____ Primary Number _____ Alt Number _____

Emergency Contact Person OTHER than Parent/Legal Guardian _____
Relationship to Student _____ Primary #_____ Alternate # _____

Student's Medicaid Information

Does your student have a KY Medicaid or K-CHIP card? ____Yes ____No Member/MCO # _____

Does your student have any of the following life-threatening conditions that may require EMERGENCY treatment or medications to be given at school? Please mark appropriate box(es) below.

☐ **DIABETES** (Glucagon) ☐ **ASTHMA** (Rescue Inhaler) ☐ **SEIZURES** (Rescue Medication) ☐ **LIFE-THREATENING ALLERGY** (Epi-Pen) ☐ **OTHER:** _____

Student's Medical History

Significant Medical History _____
Other relevant Medical History _____
Medication Allergies _____Other Allergies_____
Food Allergies _____Dietary Restrictions_____
Medications Taken Daily _____
*Medications to be given at School _____

**Must complete additional consent form prior to any medications (over the counter or prescription) being brought to school to be administered. Forms are available from school.*

Student's Primary Health Care Provider _____ Phone # _____

I/We have completed the above medical history to the best of my/our knowledge and understand it is my/our obligation to update the above information with any changes, additions, or qualifications.

X _____ ____/____/____
(Signature of Parent/Legal Guardian/Emancipated Student) *(Date signed)*