



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 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 Yes No

Other relevant Medical History

Medication Allergies Yes No Other Allergies Yes No

Food Allergies Yes No Dietary Restrictions Yes No

Medications Taken Daily at Home Yes No

*Medications to be given at School Yes No

*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)

BACK [Arrow]

Name _____

Date of Birth _____



**LEXINGTON-FAYETTE COUNTY HEALTH DEPARTMENT (LFCHD)
SCHOOL HEALTH SERVICES
CONSENT FOR STUDENT HEALTH SERVICES**

1. 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 cleanser, 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.
2. If my student participates in Kentucky Medicaid or K-CHIP, I authorize LFCHD to release my student's medical information to Medicaid/K-CHIP to allow for billing of services provided by the school nurse, at no cost to me.
3. 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.lfchd.org or I may request a copy by calling the School Health Services Division at 859-288-2314.
4. I understand that LFCHD does not offer any health service or mental health service related to human sexuality, contraception, or family planning as defined and addressed in KRS 158.191. In the event that LFCHD changes its services to offer such a service, no such service shall be offered to my child without prior notification to me of that service and written consent for the provision of that service, unless and/or except pursuant to federal, state, or local law.
5. I further understand that LFCHD provides only basic first aid and emergency care to students, as set forth in this Consent for Student Health Services. No referral for these types of health services shall occur, unless medically necessary or on an emergency basis.

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

CONSENT FOR RECEIPT AND DISCLOSURE OF STUDENT MEDICAL INFORMATION

1. I hereby consent to LFCHD releasing medical information about my student to his/her Primary Health Provider or other Health Care Provider as necessary for purposes of treatment.
2. Kentucky law requires certain immunizations for attendance in Kentucky public schools. To the extent I provide, directly or indirectly through a third-party medical provider, the required immunization information, I consent to LFCHD entering that immunization information into the Kentucky Immunization Registry ("KYIR") on behalf of and as part of its services to Fayette County Public Schools ("FCPS"). Further, I consent to LFCHD sharing the same records or information with the Kentucky Cabinet for Health and Family Services 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.
3. I understand that nothing in this Consent and Disclosure of Student Medical Information is intended to impede, reduce, increase or have any other effect on any right that I have as a parent or legal guardian regarding access to my child's medical information.
4. 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.
5. Any information released in response to this consent may be re-disclosed to other parties.
6. No medical treatment or payment is conditioned on the signing of this consent.
7. You have a right to receive a copy of this consent form.
8. 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)