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

Student Health Information Form

Please complete one form per student

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

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 # _____

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

Last Name: _____ First 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. 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.
3. I give consent for a school nurse to perform a vision screening on my student. I understand that a vision screening does not substitute for a comprehensive eye examination by an eye care practitioner.
4. I give consent for a school nurse to perform a hearing screening on my student. I understand that a hearing screening does not substitute for a comprehensive hearing examination by a hearing practitioner.
5. 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.
6. 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.

***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. I understand that I 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)*