

**Buford City Schools Clinic Card K-8**

Name \_\_\_\_\_ “Nickname” \_\_\_\_\_ Birthdate \_\_\_\_\_ Teacher \_\_\_\_\_  
Last First

Legal Guardian(s) \_\_\_\_\_

Child’s Home Address \_\_\_\_\_

Best Number(s) to Reach Parents During the Day \_\_\_\_\_

May We Contact Parents via E-mail for Non-Emergency Situations?  No  Yes, e-mail address \_\_\_\_\_

**PLEASE LIST CONTACT NAMES BELOW IN ORDER TO BE CALLED:**

- |          |                      |            |            |            |
|----------|----------------------|------------|------------|------------|
| 1. _____ | (Relationship) _____ | Home _____ | Work _____ | Cell _____ |
| 2. _____ | (Relationship) _____ | Home _____ | Work _____ | Cell _____ |
| 3. _____ | (Relationship) _____ | Home _____ | Work _____ | Cell _____ |
| 4. _____ | (Relationship) _____ | Home _____ | Work _____ | Cell _____ |

Doctor’s Name \_\_\_\_\_ Tel. # \_\_\_\_\_ Hospital Preference \_\_\_\_\_

**LIST ANY MEDICATIONS TAKEN AT HOME OR SCHOOL AND SPECIAL INSTRUCTIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History/Problems:** Indicate **Yes** or **No**. Has your child had/has: ADD/ADHD \_\_\_ Allergies/Chemical Sensitivity \_\_\_  
(if yes, what: \_\_\_\_\_) Asthma \_\_\_ Chicken Pox \_\_\_ Diabetes \_\_\_ Heart Disease \_\_\_ Nose Bleeds \_\_\_  
Seizures \_\_\_ Sickle Cell Disease \_\_\_ Behavior/Psychological Disorders \_\_\_ Please List Other Illnesses or Important Information  
Here: \_\_\_\_\_  
\_\_\_\_\_

**My Child is Covered by:** Blue Cross/Blue Shield \_\_\_ Aetna \_\_\_ Kaiser \_\_\_ Medicaid \_\_\_ Peachcare \_\_\_ Other \_\_\_ None \_\_\_

**May We Do Hearing & Vision Screenings On Your Child If Needed?** Yes \_\_\_\_\_ No \_\_\_\_\_

List Any Siblings Also in School & Which School: \_\_\_\_\_  
\_\_\_\_\_

**PLEASE READ & SIGN!**

To ensure the safety of all students at our school, the following guidelines should be followed when medication is brought to school.

- 1. All medicine should be brought to school by the PARENT and must be taken to the office for safe storage.**
- 2. Medications both prescription and over-the-counter, must be listed on an Administration of Medication Request form, which can be obtained in the clinic when YOU bring in the medication.**
- 3. All medications must be in the ORIGINAL CHILD-PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Medications stored in envelopes, baggies, etc., WILL NOT be administered.**
- 4. Administration of prescription and over-the-counter medicine, even for a short period of time, is discouraged. Parents should check with their physician regarding the need for medications to be administered during the school hours. Medications prescribed for three times daily often can be given before school, after school and at bedtime.**
- 5. Parents must notify the school nurse immediately concerning any changes in medication(s) or dosage.**

**I grant permission for the school nurse, principal, or designee to assist in the administration of the medication listed on the reverse side of this form for my child. Any additional medication needs should be listed on the Administration of Medication Request Form that can be obtained from the office. I understand that in the event the parent/guardian cannot be reached, the school has my permission to take appropriate emergency medication action including calling 911.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date