

Buford City Schools Clinic Card 9-12

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 _____

PLEASE CIRCLE THE MEDICATION THAT MAY BE GIVEN TO YOUR STUDENT FROM THE CLINIC:

Ibuprofen Cepacol Benadryl Tums Acetaminophen Cough Drops Robitussin (cough & cold) Claritin

PLEASE LIST ANY DRUG ALLERGIES: _____

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. Additional 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 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 circled 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 clinic. 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