2023-2024 CLINIC FORM

Teacher Name **Grade**

STUDENT INFORMATION

Last Name **First Name** **Middle Name** **Birthdate** **Sex**

Parent 1/Guardian Name **Home Phone** **Work Phone** **Cell Phone**

Parent 2/Guardian Name **Home Phone** **Work Phone** **Cell Phone**

MEDICAL INFORMATION

I give permission for the school health staff to give the following medications to my child. *Please check* the boxes beside the medicine your child can have. If your child takes any of these medications on a regular basis please provide the clinic with these medicines and it will be kept on file for your child alone.

- ☐ Tylenol/Acetaminophen
- ☐ Antibiotic Ointment (Neosporin/ Bacitracin)
- ☐ Cough drops (students >12yr old) May contain eucalyptus/menthol
- ☐ Orajel/Benzocaine
- ☐ Sting Kill/Benzocaine-Menthol)
- ☐ Advil/Motrin/Ibuprofen
- ☐ Anti-itch Cream (Benadryl Cream/ Hydrocortisone Cream)
- ☐ Midol Complete (contains acetaminophen, caffeine, and pyrilamine maleate)
- ☐ Gas X/Simethicone
- ☐Tums/Calcium Carbonate (students > 12yr old)
- ☐Benadryl/Diphenhydramine (Only for allergic reaction)
- ☐Pepto Bismol/Bismuth subsalicylate
- ☐Bleed Cease

Please check all that apply:

Allergy	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Daily Medications	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Vision/Hearing Loss	☐ Yes	☐ No

Please list any information necessary for any boxes marked “Yes”:

_____

_____

Please list any other health issues that may require care at school:

_____

_____

I give the Pickens County School District permission to conduct screenings on my child:

Hearing	☐ Yes	☐ No	Nutrition (BMI/Height/Weight)	☐ Yes	☐ No
Vision	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Dental	☐ Yes	☐ No			

EMERGENCY TRANSPORTATION/TREATMENT RELEASE

In the event that I cannot be reached in an emergency situation, I give permission for the above named student to be transported to the first available hospital and authorize the hospital to provide emergency medical or surgical treatment. I will assume full responsibility for all charges related to the above and release the hospital, the school and school system, its agents, employees, administrators and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named hereon.

☐ **Yes** ☐ **No**

SIGNATURE

I have read the above and acknowledge all information provided on this form as being true and correct to the best of my knowledge.

Print Name of Parent/Guardian **Signature of Parent/Guardian** **Date**