



# Chattahoochee County School District

326 Broad Street, Cusseta, GA 31805

## NURSE FORM

SCHOOL YEAR:	GRADE LEVEL:	ENROLLMENT DATE:
STUDENT'S NAME:		
LAST NAME	FIRST NAME	MIDDLE
DATE OF BIRTH:	SCHOOL: <input type="checkbox"/> CCEC <input type="checkbox"/> CCMS <input type="checkbox"/> CCHS	
PARENT'S NAME		
ADDRESS:		
PHONE NUMBER:	ALTERNATE PHONE NUMBER:	
EMERGENCY CONTACT NAME:		PHONE NUMBER:

### MEDICAL INFORMATION

ALLERGIES		MY CHILD WILL HAVE THE FOLLOWING AT SCHOOL:		MY CHILD HAS A HISTORY OF <i>OR</i> HAS BEEN DIAGNOSED WITH:	
FOOD ALLERGIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	INSULIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	SEIZURES	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER ALLERGIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	EPI-PEN	<input type="checkbox"/> YES <input type="checkbox"/> NO	FAINTING SPELLS	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF <u>YES</u> , please list ALLERGY & REACTION here:		INHALER	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEART PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
		MEDICATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO
		OTHER:	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
				CONCUSSIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO
				OTHER MEDICAL ISSUES:	<input type="checkbox"/> YES <input type="checkbox"/> NO

**PARENT  
INITIAL HERE**

\*If **YES** to any of the information above, parents **MUST** sign an "Authorization to Give Medication at School" form **AND** any other corresponding medical forms, **BEFORE** any medication will be given at school.

The parent/guardian must transport all medication to the School Nurse.  
All **PRESCRIPTION MEDICATION** must be in the original prescription bottle. A parent/guardian is responsible for notifying School Nurse of any changes with student's medication.

I give the School Nurse/staff member permission to administer the following  
**OVER THE COUNTER MEDICATION** for minor complaints to my child while at school.  
I do hereby release Chattahoochee County School System & School Nurse/staff member from any adverse reaction that might occur as a result of taking these medications. **(CHECK BELOW)**

<input type="checkbox"/> ACETAMINOPHEN (EX: TYLENOL)	<input type="checkbox"/> BENADRYL	<input type="checkbox"/> ANTIBIOTIC OINTMENT
<input type="checkbox"/> IBUPROFEN (EX: ADVIL)	<input type="checkbox"/> ANTACID (EX: TUMS)	<input type="checkbox"/> HYDROCORTISONE CREAM
<input type="checkbox"/> COUGH DROPS OR THROAT LOZENGES		

Parent/Guardian must **INITIAL ABOVE & SIGN BELOW** for medication to be given at school.  
This form must be completed by a parent or guardian **EVERY school year.**

**PARENT SIGNATURE:**

**DATE:**