HEALTHY STUDENT PROGRAM APPLICATION FORM 2018 - 2019

Dear Parent:

Your child is eligible for enrollment in the **Healthy Student Program**, available only at ***selected schools*** *(only administered by clinic assistant or school nurse)* in the District where there are extended nursing services. **Healthy Student Program** services are offered at no direct cost to you and all students are eligible, regardless of insurance.

The main purpose of the **Healthy Student Program** is to **improve school attendance** and to **reduce health problems** that occur during the school day. A student may be withdrawn from the **Healthy Student Program** at any time by the parent or the school health services staff with written notice.

The Healthy Student program is the commitment of the Pasco County School District, and is intended as an effort to help students remain in school, ready to learn. Services available to students enrolled in the **Healthy Student Program** may include:

- **Management of acute illness or injury and the administration of limited medications,** following physician guidelines and protocols (i.e. ibuprofen, Tylenol, Motrin, Robitussin, Tums, and antifungal ointment, Benadryl, hydrocortisone, etc.).
- **Observation and follow up re: communicable diseases** (i.e. pink eye, ringworm, etc.).
- **A health professional will communicate with you** about your child's particular health findings that may require an evaluation, follow up or referral.
- **Physical Examinations** (ARNP services) for school entry, sports, etc. may be available at limited school sites.
- **Lab screenings** (hematocrit/hemoglobin, anemia, blood glucose, urinalysis, and pregnancy testing) may be available at limited school sites.

Please inform the school nurse of any newly diagnosed health conditions for your child or changes in health status during the school year.

The primary goal of school health services is to support academic success by maintaining the physical and mental well being of your child.

TO ENROLL YOUR CHILD IN THE HEALTHY STUDENT PROGRAM:

- Please complete the application for Healthy Student Program Membership
- Be sure to complete "Student Medical History" section
- Parent signature is required below the "Enrollment Statement"
- Return completed form to the school clinic assistant or school nurse

All medical information remains confidential between you and the health services provider. Records are stored and maintained within the Health Office and are shared with no one as per HIPAA compliance. The Medical Director of the Pasco County Health Department provides oversight for this program.

APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2018 - 2019

Student Name _____ Sex _____ Grade _____ DOB _____
(Last, First, MI)

Student # _____ Home Address _____ Home Phone _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Parent Name	Place of Business	Business Phone	
Backup Person to be Called		Home Phone #	Cell Phone #

STUDENT MEDICAL HISTORY

List any ALLERGIES to Medications or Food: _____

List any SURGERY/HOSPITALIZATION: _____

_____

List any CURRENT MEDICATIONS: _____

List any MEDICAL / HEALTH PROBLEMS: _____

_____

_____

FAMILY MEDICAL HISTORY: (Circle all that apply and indicate which family members have or have had the condition)

High Blood Pressure _____ Tuberculosis _____ Diabetes _____
Epilepsy _____ Sickle Cell _____ Cancer _____
Heart Problems _____ Asthma _____ Arthritis _____

Name of Family Physician _____ Phone _____

Name of Family Dentist _____ Phone _____

Date of Student's Last Physical Exam _____ Last Dental Exam _____

ENROLLMENT STATEMENT

We agree to enroll _____ in the Healthy Student Program. We understand that the program offers a limited range of HEALTH COUNSELING services on an as-needed basis. We further understand that these services DO NOT REPLACE the services of our family doctor. In case of accident or serious illness, the school policies outlined on the School's Emergency Information Card will be observed. We further understand that student information is confidential except in those instances when professionals are required by law to report child abuse, death threats, suicide risk, and public health concerns.

Parent/Guardian Signature _____ Date _____

Pasco County Schools

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2018 - 2019 Student Medication Administration Record (MAR)

Student Name: _____ Student #: _____ Grade: _____ DOB: _____ School: _____

Medication: _____ Dosage/time(s) to be given: _____ Exp. Date: _____

Allergies: _____ Special Instructions: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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June																															
July																															

Codes: A = Absent N = Medication not sent by parents O = No Show Teacher / Extension: _____

Date: Amt. Med. Recd.: Signatures (2 employees and parent/guardian if available):

_____ _____ _____ / _____ / _____

_____ _____ _____ / _____ / _____

Initials and name of persons administering or counting medications:

_____ _____

_____ _____

Note: This form must be saved for 7 years

Attach student photo if available