RUSINGA SCHOOLS NAIROBI

Authorization and Consent for Medical Treatment of Student Bythe School Nurse

Please return to school: The school nurse cannot/will not provide services to your child without this signed consent (except for emergency first aid). The consent can be reviewed at any time by the parent or guardian.

- **CHILD/STUDENT INFORMATION:**

Does your child have any allergies to foods, medications, or environmental pollens?

Yes ( ) No ( )

If yes, please list all allergies:____

Teacher ____ Year ________________

Child's Name: _______________________________________

Date of Birth: ______________________

Blood Group:
Nationality: ________________ Sex: Male ( ) Female ( )

Child's Street Address: _____________________________City: __________________

How many people live in the home? ________

Mother's Name: ____ Home Ph.: ________________

Work Ph.: ___________________________________ Cell Ph.: ___________________________

Father's Name: ____ Home Ph.: ________________

Work Ph.: ___________________________________ Cell Ph.: ___________________________

Guardian: ____ Home Ph.: ________________

Work Ph.: ___________________________________ Cell Ph.: ___________________________

EMERGENCY Contact Person other than guardian or parent listed above ______________________

Relationship to student ____

Home Ph.:__________________________________ Cell Ph.: _________________________

Child's Medical Insurance

Does your child have Medical Insurance?   Yes (   ) No (   )

If yes, with which company?--------------------------------------

Policy Number ______________________

Is your child fully immunized?   Yes ( ) No ( )

Kindly provide the copy of the immunization card.

Does your child take school lunches?   Yes ( ) No ( )

Does your child have any food allergy?   Yes ( ) No ( )

If yes, please specify --

Doctor's Details:

Name:--

Mobile Number: --

Office Number: ---

Email Address: ---

Physical Address:---

Please list any medication your child is taking for a long-term illness or on a regular basis:

____

You will be asked to complete a separate Medication Consent Form if you desire the School Nurse to administer medication in the school

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The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate item if your child has ever had/has any of the following.

______ ADD/ADHD
______ Anaphylactic Reaction
______ Anemia
______ Asthma
______ Birth defects
______ Blood transfusion
______ Chest pain
______ Chicken pox
______ Depression
______ Diabetes
______ Emotional/psychiatric problems
______ Exposed to Tuberculosis
______ Head, eyes, ears, throat problems
______ Hospitalization
______ Joint or muscle pain or stiffness
______ Leukemia
______ Measles
______ Stomach or bowel problems
______ Unexplained weight gain
______ Unexplained weight loss
______ Operations/surgeries
______ Rheumatic Fever
______ Scarlet Fever
______ Seizures/ Convulsion
______ Serious illness or injury
______ Sleep problems
______ Shortness of breath
______ Mood disorders
______ Mumps
______ Persistent cough
______ Unexplained tiredness
______ Nosebleeding

If you check yes to any of the above conditions, please provide additional information such as specific type, name of illness or treatments required:

____

____

Have there been any recent situations in the family that you feel might negatively affect your child?

Yes/NoIf yes, please explain:

____

Does your child use/has used any of the following substances to the best of your knowledge?

<u>Tobacco</u>?Yes ( ) No ( ) **<u>Alcohol</u>?** Yes ( ) No ( ) **<u>Prohibited Drugs</u>?** Yes ( ) No ( )

Please specify if any of the student's family members have had any of the listed health problems by using the code:

S=sibling, F=father, M=mother, GF=grandfather, GM=grandmother and also identify the grandparent by P=parental or M=maternal (example: the mother's parents would be listed as MGF for maternal grandmother).

______ Cancer ______ Heart Disease ______ Stroke ______ Birth Defects
______ Anemia ______ High Blood Pressure ______ Kidney Disease ______ Epilepsy
______ Seizures ______ Diabetes ______ Tuberculosis ______Respiratory disorders

This consent covers basic laboratory tests that can be provided at the school health clinic when requested by a parent or are a required part of a physical exam. These include blood sugar levels which require a finger stick and a urine test and blood pressure.

Please remember that if you do not complete this form, sign it and return it to your child's teacher at school, the nurse will notbe allowed to care for your child except in a real emergency situation.

______ Yes, I give my consent for my child, __________________________ to receive services at the Health Department Satellite School Clinic. (Name of student)

______ No, I do not wish my child, __________________________ to receive services at the Health Department Satellite School Clinic,except in a real emergency situation.

By signing this consent, I release Rusinga Schools from any liability related to the administration of medication or treatment so long as reasonable care and (customary) care is provided.

Signature of Custodial Parent/Legal Guardian: ____

Date: ______________

(This consent form does not include injectable. You must contact the school nurse for this or she will contact you for a separate consent for that service.)

Authorization and Consent for Medical Treatment of Student by the School Nurse

CONSENT FOR HEALTH SERVICES

I consent to health care which may include screening, examination, assessments, lab tests, treatment, first aid, over the counter medicine, and any other health services given to me/my child by staff or agents of the Rusinga Schools Health Department. I understand that no guarantees are being made as to the effect of any exam or treatment on me or my child/ until certified by a physician.

I understand that my child's medical record, kept in the school health clinic, may not be shared with anyone without my written consent. I authorize the school health clinic to release medical information about my child to a secondary health provider. I also understand that the information obtained from the child's medical examination,including immunization, will be released to my child's school on admission.

If my child has any medical bill from a secondary Health provider, I also authorize the school clinic to release this information to me so that I can be billed.

EXPIRES AFTER EVERY ACADEMIC SECTION.

A New Form on Entry to a New Section Must be Filled.

(KINDERGARTEN, PREPARATORY, SENIOR AND A-LEVEL)

If the parent /guardian feels that they require to update any information on the form it can be done on request.

____ DATE _____________

SIGNATURE OF PARENT/LEGAL GUARDIAN

RECEIPT OF PRIVACY NOTICE ACKNOWLEDGEMENT

Patient's Name (Print) ____

Date of Receipt _____________________________ 20____

By signing this form, you acknowledge that the Rusinga Schools Health Department has given you a copy of its Privacy Notice, which explains how your child's health information will be handled in various situations.

Check all that are true:

( ) I have received the Rusinga Schools Health Department Privacy Notice.

( ) I understand that I may contact the Health Department and I will be given an opportunity to discuss my concerns and questions about the privacy of my child's health information.

____

(Signature of parent/legal guardian)

OFFICIAL USE ONLY

To be completed by the Admissions Officer: 1.Does the Parent/Legal Guardian have a copy of the Privacy Notice? ( ) Yes ( ) No

Explain briefly why the Parent/Legal Guardian was unable to sign an acknowledgement form.