Brantley County School Health Services

Student - Health Profile & Consent for School Health Services - NURSE FORM

2026 - 2027

STUDENT Demographic Information

STUDENT Name: _____ **DOB**: ____/____/_____ **Age**: _____

School: ❑ BCHS ❑ BCMS ❑ HES ❑ NES ❑ NPS ❑ AES ❑ WPS **Homeroom Teacher**: _____ **Grade**: _____

Child's Health Insurance Name: ❑ None ❑ State (Medicaid/PeachCare/Peach State/etc.) _____ ❑ Private _____

PARENT/GUARDIAN Name(s): _____ **Phone #**: _____

Phone #: _____ **E-mail Address**: _____

- **Parent/Guardian Place of Employment**: _____ **Work Phone**: _____

OTHER Emergency Contact: _____ **Phone**: _____ **Relation**: _____

OTHER Emergency Contact: _____ **Phone**: _____ **Relation**: _____

STUDENT Medical Information

Primary Provider: _____ **Specialist**: _____ **Dentist**: _____

Hospital of choice: ❑ Brunswick ❑ Waycross ❑ Jesup ❑ Other: _____

PreExisting Conditions:

Condition	Yes	Comments	Condition	Yes	Comments
Asthma or Breathing Condition			Head Injury, concussion		
AttentionDeficit/Hyperactivity Disorder			Hearing Conditions or Deafness		
Behavioral/Psych/Social Conditions			Heart Problems/Defect		
Developmental Conditions			Lead Poisoning		
Bladder Condition			Muscle Conditions		
Bleeding Condition			Seizures/Epilepsy		
Bowel Condition			Sickle Cell Disease		
Cancer			Speech Conditions		
Cerebral Palsy			Spinal Injury		
Cystic Fibrosis			Surgery(s)		
Dental Health Condition			Vision Conditions		
Diabetes: ❑Type 1 ❑Type 2			Other		
Insulin Pump					

Allergies (severe/life threatening):

Types: ❑ Plant ❑ Food ❑ Insect ❑ Medication ❑ Animal ❑ Latex ❑ Other

Name(s) of allergen(s)	Reaction	Treatment

If you checked YES to any chronic condition or severe allergy, or if there is another health condition, it is YOUR responsibility to* ***contact the school nurse *about having a care plan on file. Please provide details to any YES conditions or additional health conditions on the back of this form.***

Medications:

(List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly)

Medication Name	Dosage	Time Administered (Home/School)	Notes

Parental/Guardian Consent for School Health Services

I give my consent for the above-named child to participate in the School Health Services Program, which may include vision, hearing, height, weight, body mass index, nutrition, dental, scoliosis screenings, health appraisals, hygiene and health related issues, and nursing assessment.

I give my consent for my child to receive routine first aid administered by the school nurse or principal designee in the case of minor accidents or injury.

I give permission for the school nurse or principal designee to provide emergency care and to seek emergency medical services for my child if necessary. In

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the event that the situation is very serious, 911 will be called and the student will be transported to the nearest emergency room. Fees for transportation and medical services will be the responsibility of the parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Additional Information: (MARKED HEALTH CONDITIONS / OTHER CONDITIONS)

SPECIFIC REQUESTS: regarding medication administration or care

Parent/Guardian Signature: _____ Date: _____

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