MEDICATION POLICY

Baltimore County Public Schools has a medicine policy that is strictly enforced at Woodlawn High School. Any physician ordered medication must be brought to the school nurse, in the original, labeled, prescription bottle **ACCOMPANIED** by a completed medication form.

Additionally, the school nurse may find it appropriate to administer a non-prescription medicine for your child's comfort. The nurse may only give a student medicine with a **COMPLETED DISCRETIONARY MEDICATION FORM**.

Please find both medication forms enclosed with this newsletter.

WELLNESS CENTER

Each student attending Woodlawn High School is eligible to receive comprehensive health services through the school based clinic. A pediatrician, pediatric nurse practitioner, and a Baltimore County Health Department R.N., deliver primary care to adolescents in the Health Suite. The school nurse manages this service on a bi-weekly basis. Scheduled appointments, and walk-in's are welcomed. To be eligible for this program, a completed health inventory and parent permission form must be completed and on file in the Health Suite.

Please find a health inventory and a wellness center parent permission form enclosed with this newsletter.

BALTIMORE COUNTY PUBLIC SCHOOLS
TOWSON, MARYLAND 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
TOWSON, MARYLAND 21204

PARENTAL CONSENT FORM FOR SECONDARY WELLNESS CENTER

I am granting permission for my child to enroll in the Comprehensive School-Based Wellness Center and consent to his/her receiving health related services which can include physical examinations, health screening, limited diagnostic tests, (e.g., throat cultures, blood work), education, counseling, referrals, and administration of necessary medications. I understand the school nurse is responsible for follow-up care and will have access to the Wellness Center records. You have my permission to release any wellness center information to the health care provider identified on this form.

- **NO CHILD WILL BE DENIED SERVICES BECAUSE OF INABILITY TO PAY.**

- I understand that if I have private medical care or if I belong to a clinic, this Wellness Center program can supplement this care.
- I understand that I am responsible for medical care if follow-up outside the school-based wellness center is recommended.
- I give permission to bill my insurance
- I understand that Maryland Law allows a minor to receive treatment and/or advice about sexually transmitted disease, pregnancy, drug abuse, mental health (16 years of age or older), and contraception.

Print Your Child's Name _____ Birth Date _____ Grade _____

Address: _____

Child's Social Security Number: _____

Child's Health Care Provider: _____ Telephone: _____

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Guardian: _____ Date: _____

Relationship to Student: _____ Telephone: (H) _____ (W) _____

Signature of Student: _____ Date: _____

If your child has Medical Assistance, please complete the following information:

Child's Medical Assistance Number: __ __ __ __ __ __ __ __ __ __ __

Child Receives MA Services through an HMO: YES__ NO__

If yes, name of HMO: _____

If your child's health care is covered by private insurance, please copy <u>ALL</u> the following information <u>DIRECTLY</u> from your insurance card:

1. Insurance Company's Name & Address _____

   Insurance Company's CLAIMS (Billing) Address (if different from above) _____

   Insurance Company's Phone Number _____
2. Name of individual listed on Insurance Card _____

   Policy Number of Insured Listed on Card (may be social security number) _____

   Group Number Listed on Health Insurance Card _____
3. List the name of the Policy Holder (person whose name the insurance policy is under) _____

   Social Security Number of Policy Holder _____

   Place of Employment of Policy Holder _____

   _____ Work Phone Number: ( ) _____

   Relationship of Policy Holder to Child _____

   Home Address of Policy Holder _____

If your child has no health care coverage through an HMO, Medical Assistance, or private insurance, please indicate by placing a check in this space: _____

BEBCO 82 274 96

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE!

Baltimore County Public Schools
Towson, Maryland 21204

Baltimore County Department of Health
Towson, Maryland 21204

HEALTH ASSESSMENT

- To be completed by parent/guardian -

Student Name (Last, First, Middle)	Birth Date ___Mo.___Day___Yr.	Sex (M/F)	School	Grade

Address (Number, Street, City, State, Zip) Phone No.:

Parent/Guardian Names

Where do you usually take your child for medical care? Phone No.:
Name: Address:

When was the last time your child had a physical exam?
Month: Year:

Where do you usually take your child for dental care? Phone No.:
Name: Address:

Birth History:
Birth Weight _____ Number of Days Baby in Hospital _____
Complications: _____

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have a history of or any problems with the following? Please check yes or no.

	Yes	No	Comments
Birth Defects			
Prematurity			
Hospitalization (When, Where)			
Concussion (Head Injury)			
Surgery			
Lead Poisoning			
Eye or Vision Problems			
Ear Problem or Deafness			
Speech Problem			
Cerebral Palsy			
Meningitis			
Heart Problems			
Serious Allergic Reactions			
Behavior or Emotional Problem			
Allergies (Food, Insects, Drugs, etc.)			
Asthma			
Sickle Cell Disease			
Diabetes			
Seizures			
Bleeding Problems			
Limits on Activity			
Problem with Bladder			
Problem with Bowels			
Other (Please list)			
Dates of Immunizations:			

Measles: Tetanus: Mumps: Polio: Rubella: Hepatitis:

Does your child take any medications?
_____ Yes _____ No Name of Medication(s) _____

Parent/Guardian Signature: Date:

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