Form A1 Student Name: _____ Grade: _____ DOB: _____

IVY ACADEMY'S
SKILLERN ELEMENTARY

♦ 9555 Dayton Pike Soddy Daisy, TN 37379 ♦ Phone: (423)654-7308 ♦ Fax: (423)305-7496 Attention: Nurse Bunch

Parent/Guardian Student Medical Form 2024-2025

Parent/Guardian Name: _____ Phone Number: _____

Student's Physician: _____ Phone: _____

Allergic to bee/wasp stings? ❑*Yes* ❑ *No* History of anaphylaxis? ❑*Yes* ❑ *No* EpiPen? ❑*Yes* ❑ *No*

Other allergies (medication, food, etc.) ? ❑*Yes* ❑ *No* If yes, please list: _____

History of asthma? ❑*Yes* ❑ *No* Rescue inhaler? ❑*Yes* ❑ *No*

Does your student take medication daily? ❑*Yes* ❑ *No* Any daily prescription medications? ❑*Yes* ❑ *No*

Will your student need medication during the school day? ❑*Yes* ❑ *No* Please list: _____

_____

An Over-the-Counter Medication Permission Form must be completed if any non-prescription medications will be needed during the school day on campus or off campus and during any school-sponsored activity.This includes medications such as acetaminophen or ibuprofen. Any medication given to students during the school day must be parent/guardian provided. ***Skillern Elementary does not purchase/provide OTC medications for student use.*** *OTC medications will be securely stored in the nurse's office.*

NOTE: If your student needs medication administered daily during school hours, or uses/carries an inhaler or EpiPen is needed, a Physician Student Medical Form listing these medications is required.

My student is in good physical health and can participate in outdoor activities on and off campus. ❑*Yes* ❑ *No*

If no, please explain: _____

_____

List any conditions that have been diagnosed by a physician, psychologist, or psychiatrist:

_____

_____

_____

With your consent, Skillern Elementary will provide the following medications/treatments: hydrocortisone cream, antibiotic ointment, and topical treatments for poison ivy and other skin irritations (calamine lotion, sting relief wipes, etc.). In cases of emergency: diphenhydramine (Benadryl) may be administered. Your signature below serves as consent for your child to receive the above treatment(s).

I DO consent to the use of these medications for my child _____

I DO NOT consent to the use of these medications for my child _____

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Skillern Elementary Policies (based on HCS and state guidelines/policies):

1. All prescription medications must be in the original prescription bottle.
2. Students are not allowed to have medications with them during the school day. ***This includes over the counter medications such as ibuprofen (Motrin), acetaminophen (Tylenol), etc.***
    a. EpiPens and albuterol inhalers are allowed with a physician order.
    b. This does not include non-medicated cough drops; they are permitted.
3. Students are *not* allowed to have medications on the school buses, with the exception of those with self-carry orders for inhalers, EpiPens and diabetic supplies.
4. Elementary School students are **NOT** permitted to drop off medication!
5. All prescription medications require a physician's signature in order for Skillern staff to administer medication.
6. If your student needs medication while attending a school-sponsored Field Study, a *Field Study Medication Form must be completed.* Prescription medications require a physician signature.
7. Over the counter medications can be dispensed to students by the nurse or a trained staff member. An OTC medication form must be completed by the parent or guardian, and a student supply must be left in the clinic/high school office. The OTC medication must be in the original container, and the container should be labeled with the student's name. **NO LOOSE PILLS WILL BE DISPENSED.**
8. All students are expected to hike and participate in outdoor class related activities unless we have a written statement from a physician. The note should include a specified time period for restrictions, or list the date of followup evaluation.

Acknowledgement and Consent For Treatment

I, _____ (parent/guardian) of _____ (student), authorize Skillern Elementary staff to seek medical treatment as needed during the 2024-2025 school year. My signature below also affirms I have read the above information regarding Skillern Elementary policies. I understand it is my responsibility to update Skillern Elementary of any changes to my student's medical history, including new diagnoses and medication changes. I authorize the nurse at Skillern Elementary to communicate with my student's doctor via phone, email or fax in order to provide the best possible care for my child.

Parent/Guardian Signature _____ Date: _____

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Please attach an updated copy of the TN Immunization form (available from your healthcare provider) if any of the following apply to your student:

1. Your student is coming to Skillern from a state other than Tennessee.
2. Your student is coming to Skillern from any school that is not part of the Hamilton County School District.
3. Your student will be in Kindergarten for the 2024-2025 school year.
4. You have been notified that your student does not have an up-to-date immunization record on file at Skillern, and you have not yet submitted a new form.
5. Your student has been vaccinated since the last time you submitted this form.

The TN Immunization form is also available through the Hamilton County Health Department, should you choose to have your child immunized there. They offer minimal cost vaccinations through the Vaccines for Children (VFC) Program, provided by the TN Department of Health. Call (423) 209-8000 for more information. Per the TN Dept. of Health: "Unless specifically exempted by law, Tennessee law requires a certificate on file for each child in attendance in any school or child care facility in Tennessee."

Form A2 Student Name: _____ Grade: _____ DOB: _____

IVY ACADEMY'S
SKILLERN ELEMENTARY

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Physician Medical Form/ISMO 2024-2025

Individualized Student Medical Order (ISMO)

ALLERGIES: ❑ ***Yes*** ❑ ***No*** List: _____ History of Anaphylaxis? ❑ *Yes* ❑ *No* EpiPen? ❑ *Yes* ❑ *No* Self-carry EpiPen? ❑ *Yes* ❑ *No* Treatment/actions: _____ _____ _____ **If epinephrine given, call 911 immediately. Notify parent/guardian.*	**SEIZURES:** ❑ ***Yes*** ❑ ***No*** Does student have rescue medication? ❑ *Yes* ❑ *No* Medication: _____ Treatment/actions: _____ _____ **Call 911 if: 1st seizure, different or prolonged seizure pattern, repeated seizure, no breathing or pulse (start CPR), or if Diastat given and: a)Administered by non-medical staff; b)Nursing judgment indicates medical emergency based on situation and assessment; c)Parent or MD requests 911 call with seizure.*
ASTHMA: ❑ ***Yes*** ❑ ***No*** Rescue inhaler? ❑ *Yes* ❑ *No* Self-carry inhaler? ❑ *Yes* ❑ *No* Treatment/actions: _____ _____	**OTHER HEALTH CONDITION:** _____ _____ Treatment/actions: _____ _____

Prescription Medication List

This includes daily medications during school hours, or medications needed during school-related activities/overnight field trips.

Name of Medication	Indication	Dosage	Route	Time	Side Effects	D/C Date

Notes:

Physician's Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Physician Address: _____ City: _____ Zip: _____

Parent Name: _____ Parent Phone Number: _____

Parent Signature: _____ Date: _____

Parent signature required to implement above plans. If your student has "self-carry" orders, your signature serves as verification your student is capable of responsibly carrying and administering listed medications.

Students are responsible for bringing/carrying self-carry medications with them to school/school-related events.