Graves Gilbert Clinic

SLCT

School Health Questionnaire

Students Legal Name: _____ DOB:_____

Parent/Legal Guardian: _____ Phone: _____

Pediatrician or Family Doctor: _____

Insurance Carrier:_____ Effective Date: _____
Policy Number: _____ Medicaid ID: _____
Subscribers Name: _____ Date of Birth: _____
Subscribers Address: _____

1. Past Medical Diagnosis, Hospitalizations and/or Surgeries:

_____
_____

2. Current Medications: Name and Dosage (Include vitamins, herbs, supplements, and oil)

_____
_____

3. Doctor Diagnosed Asthma: ☐ Yes ☐ No

Triggers: ☐ Pollens ☐ Dust ☐ Animals ☐ Foods
☐ Exercise ☐ Heat ☐ Illness ☐ Scents/Perfume
☐ Smoke ☐ Seasonal ☐ Others: _____

4. Doctor Diagnosed Allergy : ☐ Yes ☐ No

Allergy to: _____

5. Medication Needed at School: ☐ Yes ☐ No If Yes, explain: _____

6. Medical Procedures Needed at School: ☐ Yes ☐ No If Yes, explain: _____

Family History:

Check any of the following that parents, grandparents, siblings, aunts, uncles, or cousins may have had:
☐ Asthma ☐ Childhood cancers ☐ Heart Attack less than 35
☐ High Cholesterol ☐ Sickle Cell Disease/Trait
☐ Other: _____

Please list any other individuals who you give permission for us to communicate with about your child's medical condition.

Name: _____ Relationship: _____ Contact #:_____

Name: _____ Relationship: _____ Contact #:_____

It is the guardian's responsibility to notify the school health office in writing if above contacts or any health information changes. I also acknowledge receipt of Graves-Gilbert Clinic's Notice of Privacy Practices.

Parent/Legal Representative Printed Name: _____

Parent/Legal Representative Signature: _____

Date: _____ Relation: _____

CONSENT VALID FOR SCHOOL YEAR 2025-2026

Graves Gilbert Clinic

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SCHOOL BASED TELEHEALTH OR OFFICE BASED CONSULTATION AGREEMENT FOR TREATMENT

I request and consent to having my child _____ examined and evaluated by medical providers affiliated with Graves-Gilbert Clinic by means of interactive/video. This telemedicine consultation may be used to help diagnose, manage, or treat my child.

In addition, I understand and agree to the following:

- The consulting health care provider or specialist *will be* at a different location from my child. The school nurse or other qualified practitioners will be present with the child in the room to assist in the examination and evaluation. I may attend electronically or in person as well if I provide information allowing me to be reached in a timely manner.
- Additional technical personnel may be present during the consultation as needed to operate the telemedicine equipment.
- This telemedicine consultation program is not replacement for my child's primary or specialty care, and is being provided to enhance the school based health service
- The results of the examination will become a part of the child's medical record, which could include video and/or audio recording of the session as deemed appropriate by the consulting provider or specialist. The consulting provider or specialist will send the results of the teleconferenced visit to your child's primary care provider.
- The consulting provider or specialist may recommend additional tests and treatment, and it is my responsibility to follow-up on such recommendations.
- Although the equipment and resources are designed to protect patient confidentiality and to provide accurate and timely transmissions, the risk remains for technical difficulties, interruptions, and unauthorized access.
- Your child's school and Graves-Gilbert Clinic will attempt to reach you before the telemedicine visit takes place, however, in the event we are unable to contact you, you give your permission for the telemedicine visit to take place, and Graves-Gilbert Clinic will send you a summary of the visit and recommendations that were made.
- Telehealth consultations may be billed to my insurance when appropriate. I authorize direct payment to the clinic of the benefits provided under any health care plan or medical expense policy due to me or payable by the plan. I further authorize the clinic to release any information required by any third party payer regarding any claim for payment.
- The Graves-Gilbert Clinic Provider at times may be present in my child's school. I authorize an in person consultation with the provider with the same terms as above.

☐ **Yes, I agree to the above terms. My child may be consulted by the Graves-Gilbert Clinic Provider via Telehealth or Office Based Visit.**

☐ **No, I do not want my child to be consulted by the Graves-Gilbert Clinic Provider.**

Child's Name: _____ Date of Birth: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Relation: _____ Date: _____ Time: _____

CONSENT VALID FOR SCHOOL YEAR 2025-2026

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Over-the-Counter Medication

Student's Name: _____ Grade: ____ **ALLERGIES:**_____

Student's Age: _____ Date of Birth:_____ School:_____

Please indicate by checking below the medications you permit to be administered to your child.

☐ **Acetaminophen (Tylenol)**	☐ **Antibiotic ointment**	☐ **Eye drops/wash**	☐ **Aloe Vera**
☐ **Calamine Lotion**	☐ **Ibuprofen**	☐ **Oragel**	☐ **Cough Drops**
☐ **Loratidine Allergy (Claritin)**	☐ **Antacid Tablet (Tums)**	☐ **Hydrocortisone Cream**	☐ **Anti- Nausea (Emetrol)**
☐ **Lip Ointment**	☐ **NONE OF THE ABOVE**		

- I authorize the nursing and medically trained staff at Bowling Green Independent School District and Graves-Gilbert Clinic to provide over the counter medication as noted above and as needed to my child.
- I understand that it is my responsibility to directly notify the nursing staff in writing at the school where my child is enrolled of any changes in my child's OTC medication needs.
- I understand that in the event of an adverse reaction to any OTC medication, the medication will be halted, and I will be notified by the nursing staff at the school.
- I understand that this permission form will be kept on file in my child's student health record and will not be changed without written notification.
- I understand that this document's confidentiality is governed by FERPA (Family Education Rights to Privacy Act) and that all rules under such Act will be followed by all parties.
- I understand that a generic equivalent may be administered to my child.
- I expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication.
- I understand that I must provide to the school nursing staff a signed physician's order/statement in order to exceed the recommended dosage guidelines (as printed on the bottle/packaging) when administering the indicated medications.

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Printed Name *Relationship*

Graves Gilbert Clinic

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Vision and Hearing Screen Consent Form

Per 702 KAR 1:160. School health services. Regulation 9 states: (9)
(a) A board of education shall adopt a program of continuous health supervision for all currently enrolled students.
(b) Supervision shall include scheduled screening tests for vision and hearing.

BGISD implements the following screenings per grade level:
Kindergarten: Hearing
1st Grade: Hearing
2nd Grade: Hearing
3rd Grade: Hearing & Vision
5th Grade: Vision

If a staff member has a concern for a student's hearing or vision outside of the regularly scheduled school wide screenings, school health services may be asked to perform a screening on the child.

Check below if you give permission for your school nurse to perform hearing or vision screenings.

—-------Yes I give permission for my child to have hearing or vision screening completed per grade level or school staff concern.

_____No I do not give my child permission to have hearing or vision screening completed per grade level or school staff concern.

Name of Child:_____ DOB:_____

Guardian Signature:_____ Date:_____