VIRGINIA SCHOOL FOR THE DEAF AND THE BLIND

PERMISSION FOR ROUTINE AND EMERGENCY
MEDICAL, DENTAL, OR MENTAL HEALTH CARE

PLEASE COMPLETE ALL QUESTIONS

Student Name_____ Date of Birth _____

Parent/Guardian Name(s)_____

_____

Phone # (_____)_____ Home Address_____

Phone # (_____)_____ _____

Phone# (_____)_____ Email Address_____

Emergency Contact _____ Phone # (_____)_____

Insurance Company (attach copy of card): _____

List any medical issues/concerns that nursing staff should know to care for your child:

_____

_____

PLEASE NOTE: If your child has asthma, allergies that require an Epi-Pen, diabetes, and/or seizures, VSDB requires an annual Action Plan to be completed by a physician and signed by the parent.

Current Medications (all medications, including over the counter, require written physician orders, signed by the prescriber and the parent):

_____

_____

Allergies to food, medication, insect & reaction:_____

_____

Epi-Pen __ Yes __No

Special dietary needs: _____

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Name of Student _____Date of Birth _____

Parent/Guardian: Your initials in front of each statement and your signature at the end of the page indicate your understanding and consent.

_____ 1. I give consent for the VSBD nurses and medication aids to administer all medication ordered by my child's health care providers. I also give permission for the nurses to contact the health care providers regarding the administration of my child's medications. I understand that I am responsible for providing all prescribed medications in the original container from the pharmacy.

_____ 2. I understand that I need to keep a weekend and holiday supply of all my child's medications at home.

_____ 3. I understand that I am responsible for maintaining primary care providers for the medical, dental and vision needs of my child. I will provide an annual report of physical examination and dental examination to the school, as it is a requirement for my child's enrollment.

_____ 4. I give consent for VSDB to exchange medical records with my child's physicians/health care providers including office visit/procedure notes, medical orders, and treatment plans to maintain continuity of care between the home and school settings. I understand that granting this permission is voluntary and that I may revoke this permission in writing at any time. This authorization will expire one year from today's date.

_____ 5. I give consent for VSDB staff to transport my child to off campus medical appointments, including to the local hospital emergency department when necessary. I understand that I am responsible for all fees incurred by my child at off campus medical appointments.

_____ 6. I understand that I am responsible for keeping my child's immunizations current, in accordance with the Virginia Department of Health and the Code of Virginia. My child will be unable to attend school if he/she is not adequately immunized or proper documentation of exemption is not provided.

_____ 7. I understand that the Student Health Center is staffed with Registered Nurses from 6:30 a.m. – 12:30 a.m. when school is in session. A physician from Augusta Pediatrics, Fishersville, VA, is on call 24 hours a day for consultation.

_____ 8. I understand that the Augusta Pediatrics physicians provide standing orders for medical treatment and care of all students at VSDB. These orders contain a list of over-the-counter medications that the nursing staff can administer to my child when necessary. Parents can receive a copy of these orders upon request.

_____ _____

Signature of Parent/Guardian Date