STUDENT HEALTH INFORMATION

2023-2024 School Year

______________________________ Student's Name

______________________________ Date of Birth

______________________________ School

______________________________ Teacher

__________ Grade

☐ **My child has NO medical conditions, health concerns, or special medical needs at this time.**

☐ **My child HAS THE FOLLOWING MEDICAL conditions, health concerns and/or special medical needs:**

	ADHD/ADD		Diabetes (Type 1 or 2)		Seasonal Allergies
	Asthma		Drug Allergies		Congenital Abnormality
	Bee Sting Allergy		Epilepsy/Seizures		Heart Condition
	Cancer/Leukemia		Milk* Allergy		Behavior/Mental Health
	Cerebral Palsy		Other food allergies		Other

Allergies (Please list food and drug allergies)

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Other Medical Conditions (Please list any medical conditions or concerns not listed above)

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Please check any medications your child may need at school (specify when checking other)

	Benadryl		Inhaler		(Other)
	Diastat		Insulin		(Other)
	Epi-pen		Nayzilam		(Other)
	Glucagon		Valtoco		(Other)

Please specify any other health information that applies to your child

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I consent to share this information with district staff, such as, principals, teachers, secretaries, and food service staff. I authorize school personnel to exchange information with my child's health care providers by telephone, fax, and email or in writing to facilitate coordination and continuity of care. Please contact the school nurse to discuss any health concerns or special medical needs of your child.

______________________________ Doctor/Health Care Provider

______________________________ Phone

______________________________ Parent/Guardian Signature

______________________________ Date

______________________________ Home Number

______________________________ Work Number

______________________________ Cell Number

*A note from your doctor is required for a substitute drink at school.

Office of School Culture - Nursing Department

Lansing School District
2023-24

Consent and Registration Form for Rapid COVID-19 Antigen Test

First Name: ___________________________ Last Name: _________________________________

DOB: ____________________ School: ____________________________________

Please carefully read the following informed consent:

Please carefully read the following notice and sign the authorization to test for COVID-19.

1. I understand that the COVID-19 testing will be conducted through a BinaxNOW antigen test, or other acceptable test as ordered by an authorized medical provider or a public health official.
2. I understand that my ability to receive testing is limited to the availability of test supplies.
3. I understand that I am not creating a patient relationship with the ordering physician by participating in this testing. I understand the entity performing the test is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results and my medical care. I agree I will seek medical advice, care, and treatment from my medical provider or other health care entity if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens.
4. I understand it is my responsibility to inform my health care provider of a positive test result, and that a copy will not be sent to my health care provider for me.
5. I understand that my antigen test result will be available in 15-30 minutes. If the result is positive, it will need to be confirmed with a PCR test.
6. I understand and acknowledge that a positive antigen test result is an indication that I need to self-isolate to avoid infecting others until I obtain a negative PCR test result.
7. I have been informed of the test purpose, procedures, and potential risks and benefits. I will have the opportunity to ask questions before proceeding with a COVID-19 diagnostic test at the testing site. I understand that if I do not wish to continue with the COVID-19 diagnostic test, I may decline to test.
8. I understand that to ensure public health and safety and to control the spread of COVID-19, my test results may be shared without my individual authorization.
9. I understand that my test results will be disclosed to the appropriate public health authorities as required by law.
10. I understand that I may withdraw my consent to participate in testing at any time.

AUTHORIZATION/CONSENT TO TEST FOR COVID-19

☐ I agree to undergo the COVID-19 antigen testing for the duration of the testing period and authorize my child to undergo testing.

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Patient/Parent/Legal Guardian Signature Date