Mount Vernon- Enola School District Clinic Record
2026-27 School Year

Parent or Guardian: This form **must be completed and returned** in order for the nurse and other school staff to provide the best care to your student. If the medication release is not signed and medications are not checked, your student will not be given any over the counter medications.

Student Name:_____ Grade:_____

Home Address:_____

Parent/Guardian:_____ Phone:_____

Parent/Guardian:_____ Phone:_____

Primary Care Doctor:_____ Phone:_____

Preferred Hospital:_____

If parent/guardian is unavailable, whom do we contact in case of an emergency?

Name Relationship to Student Phone #

1._____

2. _____

Does your child have any of the following ***documented*** medical conditions currently?

☐Asthma ☐ADD/ADHD ☐Diabetes ☐Blood Disorder ☐Hearing/Vision Problems
☐Heart Condition ☐Seizures ☐High Blood Pressure ☐Migraines ☐Depression/Anxiety

☐Bowel/Bladder ☐Other(specify): _____

Will your child need any special accommodations, medical procedures or medications while at school due to a diagnosed medical condition? ☐Yes ☐No **If yes, please contact the school nurse.**

Non-Life Threatening Allergy:_____

Reaction to allergen:_____

Severe/Life-Threatening Allergy to NUTS, LATEX, STINGS or OTHER (specify):_____

Reaction to allergen:_____

Does your child require the use of an: ☐EpiPen ☐Inhaler ☐Rescue Medicine ☐ None
****If so, please provide the medication with a written prescription from your doctor to the school nurse. Must be in the original prescription container.*

Check what medication your child is allowed to self-carry. ☐Epi-Pen ☐Inhaler ☐None

Does your child take any daily medications at home or school? ☐Yes ☐No

Please Specify:_____

If you have any questions, please contact Laken Hartness, RN at laken.hartness@mvewarhawks.org or Shelby Ragland, RN at shelby.ragland@mvewarhawks.org.

Mount Vernon- Enola School District Clinic Record
2026-27 School Year

MEDICATION TREATMENT RELEASE:

I, THE UNDERSIGNED, DO HEREBY AUTHORIZE OFFICIALS OF THE MOUNT VERNON ENOLA SCHOOL DISTRICT TO CONTACT DIRECTLY THE PHYSICIANS AND HOSPITAL AFORE MENTIONED AND DO AUTHORIZE THE NAMED PHYSICIANS OR HOSPITAL STAFF TO RENDER SUCH TREATMENT AS MAY BE DEEMED NECESSARY IN AN EMERGENCY FOR THE HEALTH OF SAID CHILD. IN THE EVENT THAT PHYSICIANS, PARENTS, OR OTHER PERSONS NAMED ABOVE CANNOT BE CONTACTED THE SCHOOL OFFICIALS ARE HEREBY AUTHORIZED TO TAKE WHATEVER ACTION IS DEEMED NECESSARY FOR THE HEALTH OF THE AFORESAID CHILD. I WILL NOT HOLD THE SCHOOL DISTRICT FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND/OR TRANSPORTATION FOR THE SAID CHILD.

PARENT/GUARDIAN SIGNATURE_____

MEDICATION RELEASE:

I, REQUEST THAT THE SCHOOL GIVE MY CHILD THE FOLLOWING NON-PRESCRIPTION MEDICATIONS THAT I HAVE INDICATED BELOW, IF DEEMED NECESSARY BY THE NURSE. I WILL NOT HOLD MOUNT VERNON ENOLA SCHOOL DISTRICT STAFF OR THE SCHOOL DISTRICT RESPONSIBLE FOR ANY UNDESIRED REACTION, WHICH MAY OCCUR, FROM THE NON-PRESCRIPTION MEDICATION LISTED BELOW. BY SIGNING I UNDERSTAND THAT I MAY NOT BE NOTIFIED UNLESS NURSE DEEMED NECESSARY.

___**NONE** ___Acetaminophen ___Tums ___Ibuprofen ___Triple Antibiotic Ointment ___Sunscreen ___Eye drops

___Benadryl (*for stings and allergic reactions only*) ___Hydrocortisone Cream ___Cough Drops

PARENT/GUARDIAN SIGNATURE_____

FIRST AID TREATMENT RELEASE:

I GIVE PERMISSION FOR MY CHILD TO BE GIVEN FIRST AID IF DEEMED NECESSARY BY THE MOUNT VERNON ENOLA SCHOOL DISTRICT STAFF IN FIRST AID PROCEDURE. I WILL NOT HOLD MOUNT VERNON ENOLA SCHOOL DISTRICT OR STAFF RESPONSIBLE FOR ANY UNDESIRED DEVELOPMENTS.

PARENT/GUARDIAN SIGNATURE _____

****

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid. In order to seek the federal Medicaid funds for reimbursements, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

****In compliance with the Family Education Rights and Privacy Act (FERPA) (20 U.S.C $ 1232g;34 CFR Part99)**

I, _____, give permission for my child ,_____'s personally identifiable information/education records to be disclosed to Mount Vernon Enola School District for the purpose of billing Medicaid.

Parent/Guardian Signature:_____ Date:_____

If you have any questions, please contact Laken Hartness, RN at laken.hartness@mvewarhawks.org or Shelby Ragland, RN at shelby.ragland@mvewarhawks.org.