

**Georgia Academy for the Blind  
Health Services Record and Consent for Treatment**

**Student Health Record**

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ F/ M

Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_  
(Please Print)

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Number \_\_\_\_\_

Work Number \_\_\_\_\_

Cell Number \_\_\_\_\_

E-Mail Address \_\_\_\_\_

What is the best way to reach you? \_\_\_\_\_

Emergency Contact 1 \_\_\_\_\_ Relationship \_\_\_\_\_

Home Number \_\_\_\_\_

Work Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Emergency Contact 2 \_\_\_\_\_ Relationship \_\_\_\_\_

Home Number \_\_\_\_\_

Work Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Who has permission to pick your child up from school? \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Allergies	Item	Reaction	Treatment
Food:	_____	_____	_____
Medicine	_____	_____	_____
Insects	_____	_____	_____
Other	_____	_____	_____

Allergic to Latex? Yes \_\_\_\_\_ or No \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Please list names and numbers of additional doctors

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give permission for my child to be treated by the Georgia Academy for the Blind Health Services nursing staff and consulting physician, Services provided include, but are not limited to the following:

<b>General Primary Nursing Care</b>	<b>Nursing Diagnosis &amp; Treatment of Acute Illnesses</b>
<b>Nursing Diagnosis and Management of Chronic Illnesses</b>	<b>Referrals for Illnesses Not Suitable for Diagnosis and/ or Treatment by nursing staff</b>
<b>Blood Pressure checks</b>	<b>Glucose Monitoring</b>
<b>Vision, Hearing, Dental Screenings</b>	<b>Health Education for Students and Parents</b>
<b>Nutrition Education</b>	<b>Administration of Prescription Medications As Ordered By Physician</b>
<b>Administration of Cream/ Ointments (Lotrimin, Caladryl, Hydrocortisone, Antibiotic Ointment, or other over the Ointments &amp; cremes</b>	<b>Administration of Over the Counter Medications (Tylenol, Ibuprofen, Maalox, Cold, Cough, Allergy Products, and Milk of Magnesia.</b>
<b>Scoliosis Screenings</b>	<b>Screening for Head Lice</b>

I also give permission for my child to be treated in an emergency room or urgent care center if deemed necessary by the nursing staff or consulting physician.

Furthermore, I give permission for the staff at the Georgia Academy for the Blind Health Services to release medical information about my child if referred to an outside medical facility.

Finally, I authorize any and all medical and health care providers to release any and all information about my child to the staff at GAB Health Services.

Parent/ Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## Visual Impairment

Is the patient legally blind, or have a condition that will render him/her legally blind in the near future? Yes \_\_\_\_\_ No \_\_\_\_\_

What is the cause of the patient's visual loss?

- Cataracts
- Macular Degeneration
- Detached Retina
- Trauma
- Glaucoma
- Diabetic Retinopathy
- Stargardts
- CMV
- Retinitis Pigmentosa
- Ushers Syndrome
- Prematurity of Retinopathy
- Other \_\_\_\_\_

Is the patient deaf or hearing impaired? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please indicate degree of hearing loss. Left Ear \_\_\_\_\_ Right Ear \_\_\_\_\_

### Primary Classification of Visual Impairment

Circle the ONE that best describes the primary classification of the individual's visual impairment.

1. Low Vision (Visual acuity of 20/70 to 20/200 in the better eye with correction.)
2. Legally Blind (Visually acuity of 20/200 or less or field restriction of 20 degrees or less in the better eye with correction.)
3. Light Perception Only
4. Totally Blind
5. Cortical Visual Impairment
6. Other \_\_\_\_\_

Child wears glasses \_\_\_\_\_ Contact lenses \_\_\_\_\_ hearing aids \_\_\_\_\_  
Prosthesis \_\_\_\_\_ Other \_\_\_\_\_ Not applicable \_\_\_\_\_

### **Communication:**

Does the child need a sign language interpreter: Yes \_\_\_\_\_ No \_\_\_\_\_

The child uses large print \_\_\_\_\_ regular print \_\_\_\_\_ Braille \_\_\_\_\_

Child is verbal \_\_\_\_\_ Non- Verbal \_\_\_\_\_

Language child speaks: \_\_\_\_\_

Language spoken in the home: \_\_\_\_\_

**Travel (check all that apply)**

- \_\_\_\_\_ Walks independently
- \_\_\_\_\_ Walks unaided, but with difficulty
- \_\_\_\_\_ Uses a cane
- \_\_\_\_\_ Requires physical support
- \_\_\_\_\_ Climbs stairs independently
- \_\_\_\_\_ Uses wheel chair  
\_\_\_\_\_ aided  
\_\_\_\_\_ unaided
- \_\_\_\_\_ Cannot climb stairs, even w/ assistance
- \_\_\_\_\_ Uses orthopedic device (e.g., braces, walker, crutches)

**Self-care skills:**

- Eating:** \_\_\_\_\_ Needs no assistance  
\_\_\_\_\_ Needs assistance, such as: \_\_\_\_\_  
\_\_\_\_\_ Special diet: \_\_\_\_\_

**Toileting (Select One):**

- \_\_\_\_\_ Needs no assistance/toilets independently
- \_\_\_\_\_ Schedule trained
- \_\_\_\_\_ Needs some assistance, such as: \_\_\_\_\_

Does student have or experience:

Explanation and Treatments

- \_\_\_\_\_ Autism \_\_\_\_\_
- \_\_\_\_\_ History of heart disease/ high blood pressure \_\_\_\_\_
- \_\_\_\_\_ Constipation/diarrhea \_\_\_\_\_
- \_\_\_\_\_ Dizziness/ fainting \_\_\_\_\_
- \_\_\_\_\_ Respiratory problems (i.e. asthma, trache etc.) \_\_\_\_\_
- \_\_\_\_\_ Seasonal allergies \_\_\_\_\_
- \_\_\_\_\_ Stroke/ muscle weakness \_\_\_\_\_