Jesup Community School Health Information

Name of student: _____ Birthdate:_____ Grade: _____

_____ Yes _____ No Asthma or bronchospasms
_____ Yes _____ No ADD/ADHD/Behavior Issues
_____ Yes _____ No Heart Problems
_____ Yes _____ No Blood pressure problems
_____ Yes _____ No Kidney/urinary problems
_____ Yes _____ No Wears glasses/contacts/vision concerns
_____ Yes _____ No Other please list below

_____ Yes _____ No Diabetes
_____ Yes _____ No Seizures
_____ Yes _____ No Migraine headaches
_____ Yes _____ No Depression/Anxiety
_____ Yes _____ No Stomach/bowel problems
_____ Yes _____ No Eczema

Comments: _____

List ALL medications taken, whether given at school or at home.

Medication	Dosage	How often given	Diagnosis	Given at School?

Please list all allergies, including foods, environmental allergies, latex or medications

Allergic to:	Reaction	Treatment

Explain any serious illness, injury or surgery that you child has had: _____

_____

Does your child have any other health or emotional concerns: If yes, please explain: _____

_____

Has your child had a: Dental visit in the last year? _____ Yes _____ No Dentist's Name _____
Physical exam in the last year? _____ Yes _____ No Name of child's physician(s) _____

I give permission for my child to receive an Epinephrine Injection if he/she is experiencing symptoms of a life-threatening anaphylactic reaction if deemed necessary by a trained individual. _____ Yes _____ No

I give permission to the school health staff to share information relevant to my child's health condition with the appropriate school personnel on an as-needed basis to meet my child's health and safety needs. _____ Yes _____ No

I give permission to the Jesup Community schools to give my child a weight appropriate dose of acetaminophen and ibuprofen if deemed necessary by school staff. _____Yes _____No

I give permission to the Jesup Community Schools to give my child antacids, cough drops, and over-the-counter topical ointments (antibiotic ointment, hydrocortisone, Caladryl, lip ointment, etc.) if deemed necessary by school staff.
_____Yes _____No If No, please specify _____

If a student requires over-the-counter pain medications more than 15 times during the school year, further permission from a healthcare provider will be required before additional doses will be given. No more than 15 doses will be given per year. Any over-the-counter medication that is taken long term at school must have a MD, DO, PA, or ARNP written approval.

_____ _____

Signature of parent/guardian **Date**

Emergency phone: _____ Hospital Preference _____

If this number changes during the school year, notify the school office immediately.