School Health Information Card

Jackson County School System

Student Name: _____, _____ Grade: _____ DOB: _____
(Last) (First)

Parent Name: _____, _____ Phone #: _____
(Last) (First)

Emergency Contact: _____, _____ Phone #: _____
(Last) (First)

Health History

Asthma	Yes / No	Hearing Difficulty	Yes / No	Food Allergies	Yes / No
Diabetes	Yes / No	Vision Difficulty	Yes / No	Other (list)	
Seizure Disorder	Yes / No	Cancer	Yes / No	List Allergies (food, medications, latex, etc.)	
Physical Disability	Yes / No	Learning Disability	Yes / No		

Please provide additional information if you answered yes to any of the above: _____

_____

Medications taken at home: _____

If your child has ASTHMA:

Will they need to carry an inhaler at school? **Yes / No** Where is the inhaler located? Clinic or On Student? If yes, an Asthma Action Plan will be required (available in clinic or BOE website).

If your child has A SEVERE ALLERGY:

Will they need to carry an EpiPen at school? **Yes / No** Where is the EpiPen located? Clinic or On Student? If yes, an Allergy Action Plan will be required (available in clinic or BOE website).

If your child has a Seizure Disorder:

Does your child have emergency medication? **Yes / No** If yes, medication: _____ A Seizure Action Plan will be required (available in clinic or BOE website).

If your child is a Diabetic:

A Diabetic Management Plan will be required. You can obtain this plan from your child's doctor and provide it to the clinic.

**The following medications/products may be given to your child when available in the school clinic when funds or donations have been made available. Generic brands may be substituted. **

******MARK OUT any of the following medications you DO NOT want your child to receive:******

IBUPROFEN	TYLENOL	SALINE EYE WASH
CALLADRYL LOTION	CALAMINE LOTION	ORAJEL
TRIPLE ANTIBIOTIC OINTMENT	HYDROCORTISONE CREAM	VASELINE
COUGH DROPS/MINTS	LOTION	STING RELIEF WIPES

In case of serious illness/injury, the school will make every effort to contact parent/guardian and telephone Emergency Medical Services (911) for immediate transport to the nearest healthcare facility. I, the parent/legal guardian, authorize the transport of and treatment by hospital emergency staff for my child.

Parent/Guardian Signature _____ Date: _____