

Date _____

**JEFFERSON COUNTY SCHOOLS
CLINIC SCHOOL HEALTH FORM**

Health information within the school is limited to the information necessary to serve the student's educational and health interests.

Student Name _____ Grade _____ Homeroom _____
Age _____ Date of Birth _____ Drug Allergies _____

_____ My child has no health problems which would affect his/her school day.

_____ My child's health needs include the conditions checked.

_____ **Allergies:** seasonal _____, food _____, bees _____ (If your child has a known food allergy, the school has to have an order from the physician stating the food allergy and what substitutions or omissions need to be made on your child's tray.)
Is an EpiPen prescribed? Yes _____, No _____ (If yes, parent must provide EpiPen)

_____ **Asthma:** Is inhaler used? Yes _____, No _____ If yes, how often? _____
Other medication taken for asthma _____

_____ **Respiratory** conditions other than asthma: _____

_____ **Diabetes:** Takes insulin: Yes _____, No _____ If yes, how often? _____
Other diabetic medications _____

_____ **Hearing or Vision Problems:** Hearing Aid? _____ Glasses? _____ Contacts? _____

_____ **Seizures:** Type _____ Date of last seizure _____
Medication taken _____

_____ **Bleeding Disorders:** Describe _____

_____ **Heart Problems:** Describe _____

_____ **Stomach Problems:** Describe _____

_____ **Kidney Problems:** Describe _____

_____ **Orthopedic Problems:** Previous Fractures? _____ Location _____
Bone/Joint Problems – Describe _____

_____ **ADD or ADHD** diagnosed? Medication taken _____
Will medication be taken at school? Yes _____ No _____

_____ **Special Procedures** needed to be performed at school. Describe _____

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List any other recurrent medical problem or illnesses you would like the school to be aware of.

If your child is allergic to any of the following, **please circle**. Many of these are often used in the schools for first aid. (Antibiotic ointment/Neosporin, anti-itch cream/hydrocortisone cream, calamine/caladryl lotion, toothache gel (Oragel or Anbesol), alcohol, and peroxide)

In case of emergency, illness, or accident, please list in order of desired action.

1. Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
2. Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
3. Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____
4. Name _____ Relationship _____
Home # _____ Work # _____ Cell # _____

If the school is unable to reach one of the above persons, depending on the nature of the emergency, one or all of the following steps may be necessary.

1. Notification to 911. Parents will be expected to pay any accompanying charges.
2. Report to the Department of Human Resources.
3. Report to a law enforcement agency.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

Please contact your school personnel for medication forms if your child needs medication at school, including inhalers for asthma or EpiPen for severe allergic reactions. Your child may carry an inhaler if medically authorized (a doctor's note will need to be on file). If your child will receive a procedure such as G-tube feed or diabetic monitoring while at school, an order must be on file before any procedure will be performed.