Student Health Information

Jackson R-2 Public Schools Student Name:_____

Grade:_____ Date of Birth:_____ Gender: M F

Does Your Child Have:	No	Yes	Please Specify:	Treating Physician
Insurance or Medicaid				
Allergies			***If yes, Allergy Action Plan Required ***	
Food				
Drug				
Other				
Allergy Requiring Epi-Pen				
Asthma			***If yes, Asthma Action Plan Required***	
Epilepsy/Seizures			***If yes, Seizure Action Plan Required***	
Diabetes			***If yes, Diabetes Action Plan Required***	
Insulin				
Heart Condition				
Kidney Disease				
Severe Nosebleeds				
Orthopedic Problems				
ADD/ADHD				
Anxiety				
Autism				
BiPolar				
Depression				
Emotional Condition				
Serious Illness				
Glasses or Contacts				
Hearing Loss				
Hearing Aid or Cochlear				
Need Restrictive PE?			If yes requires doctor documentation	
Daily Medication				
Daily Medication at School			**If yes, Medication/Self Administration Form Required**	
Other Health Concerns:				

In the event of a critical emergency the parent/guardian will be contacted first, if possible. If we are unable to contact the parent/ guardian, the emergency ambulance service will be utilized. In a critical emergency, I understand that my child will be taken to the closest hospital at the discretion of the emergency medical service (EMS). I accept full financial responsibility for the charges connected with the use of an ambulance and for charges connected with the care at the hospital. **Please initial that you have read and understand the policy above_____.**

I hereby give authorization for the school nurse, or other school employee under the direction of the school nurse, to administer over-the-counter medications. It is my responsibility to notify the school nurse of any allergies to certain medications or changes in my child's health during the school year.

Parent/Guardian Signature_____ **Date**_____