

# JACKSON PUBLIC SCHOOLS STUDENT HEALTH INFORMATION 2009-2010

School \_\_\_\_\_ \_\_\_ Male \_\_\_ Female

Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City Zip

Race \_\_\_ Native American \_\_\_ Hispanic \_\_\_ Asian American \_\_\_ Caucasian (white) \_\_\_ African American \_\_\_ Other

Doctor's Name \_\_\_\_\_ Date of last physical \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Date of last exam \_\_\_\_\_

**Does student have any of the following (please check each listing)?**

|                           |                |   |
|---------------------------|----------------|---|
| <b>Allergies</b>          | ___ Yes ___ No | To medication, food, pollen etc? List _____<br>Comments _____<br>Requires Emergency treatment? ___ Yes ___ No   |
| <b>Asthma</b>             | ___ Yes ___ No | Diagnosed by doctor? ___ Yes ___ No<br>Does student need to use inhaler @ school? ___ Yes ___ No<br>Requires Emergency treatment? ___ Yes ___ No  |
| <b>Bee Sting Allergy</b>  | ___ Yes ___ No | Diagnosed by doctor? ___ Yes ___ No<br>Requires bee sting kit? ___ Yes ___ No<br>Reaction:<br>Difficult breathing ___ Yes ___ No<br>Hives ___ Yes ___ No<br>Local Swelling ___ Yes ___ No<br>Requires Emergency treatment? ___ Yes ___ No |
| <b>Diabetes</b>           | ___ Yes ___ No | Takes insulin? ___ Yes ___ No<br>Comments _____   |
| <b>Epilepsy/ Seizures</b> | ___ Yes ___ No | Medication _____ Last Seizure (date) _____  |
| <b>Heart Condition</b>    | ___ Yes ___ No | Diagnosed by Doctor ___ Yes ___ No<br>Physical restrictions? ___ Yes ___ No<br>Medication _____<br>Comments _____<br>_____  |

**List medical information, such as any serious illnesses, surgeries or injuries in the past 12 months** \_\_\_\_\_

What **medications** are regularly taken \_\_\_\_\_ dose \_\_\_\_\_ purpose \_\_\_\_\_  
\_\_\_\_\_ dose \_\_\_\_\_ purpose \_\_\_\_\_

“In order to assure that your child is cared for appropriately, the school nurse will share information that might affect your child’s safety and well being with appropriate school personnel.”

# CONSENT FOR TREATMENT

## SCHOOL HEALTH PROGRAM FOR 2009-2010 SCHOOL YEAR

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Dear Parent or Guardian:

The School Nurse is available to provide student health care services. It is necessary for you to sign this form for your child to receive health care from the School Nurse.

I give my permission for (**child's name**) \_\_\_\_\_  
to receive basic health care treatment, health education and emergency care by the School Nurse

- Antibiotic Ointment
- Benadryl Ointment

\* **Parent/Guardian** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
This consent will be in effect for the **current** School Year

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### FOR STUDENT 12 YEARS OLD & OLDER

I give my permission for the following medication(s) to be administered by the School Nurse in accordance with the established protocols developed by the Jackson Public Schools Health Program. I verify that I am authorized to sign consent for the student named above.

- Acetaminophen (i.e. Tylenol) 325 mg      1 or 2 tablets every 4-6 hours
- Ibuprofen (i.e. Advil) 200 mg      1 or 2 tablets every 4-6 hours
- Throat Lozenges      1 or 2 lozenges every 4-6 hours
- Cough Drops      As needed
- Chewable Antacid Tablets      1 or 2 tablets as needed

\* **Parent/Guardian** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
This consent will be in effect for the **current** School Year

### **PLEASE PRINT:**

|                               |                  |
|-------------------------------|------------------|
| Mother/Guardian _____         | Home Phone _____ |
|                               | Work Phone _____ |
| Father/Guardian _____         | Home Phone _____ |
|                               | Work Phone _____ |
| Emergency Contact _____       | Home Phone _____ |
| Relationship to Student _____ | Work Phone _____ |
| Emergency Contact _____       | Home Phone _____ |
| Relationship to Student _____ | Work Phone _____ |