Jackson Independent Schools Health Form Update- Completed Annually (1 Per Student)

Medical Information

Student Name: ________________ ___________________ _____________________
(First Name) (Middle Name) (Last Name)
Physician: ____________________________ Phone: (_____) _______--_________

Are there any particular medical problems your child may be experiencing? (Please explain.)

- Physical Disabilities ____
- Medicine Allergies ____
- Asthma ____
- Diabetes ____
- Seizures ____
- Epilepsy ____
- Hearing Difficulties ____
- Kidney Problems ____
- Heart Disease ____
- Nervous Disorder ____
- Cancer____
- Tuberculosis ____
- Other ____

Is this child allergic to any foods? ☐ Yes ☐ No If yes, please list. ______________________________

Is this child allergic to any medications? ☐ Yes ☐ No If yes, please list. _________________________
____

Is this child allergic to any insects? ☐ Yes ☐ No If yes, please list. ______________________________

If this child is allergic to anything else that could cause the child harm, please list:
____

If your child has a severe allergy that could result in anaphylactic shock, we must receive a physician's statement and a sufficient supply of their prescribed medication to be kept at the school for your child's use in the event of an emergency.

Is your child currently on any routine medication? ☐ Yes ☐ No If yes, please list below:
Medication ________________________________ Dosage ________________________________
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Medication ________________________________ Dosage ________________________________

A "Permission Form for Prescribed or Over-the-Counter Medication" (Form 09.2241 AP.21) is available at the school office. This form must be completed for any medication a student will need to take during school hours.

Please attach further information if there is a serious medical issue that we need to be aware of.

Parent Signature

In case of emergency, accident, or serious illness of the above named child, I request the school to contact me. If school personnel are unable to contact me, I hereby authorize them to call the people whom I have placed on my child's emergency contact list. If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.

Parent/Guardian's Name (PLEASE PRINT) ____
Parent/Guardian 's Signature ____ Date: ______________

Date Revised 07/10/16