

**SJSD Student Health Information**  
*(Please complete and sign)*

Student's Legal Name \_\_\_\_\_ Birth date \_\_\_ - \_\_\_ - \_\_\_ Grade \_\_\_\_\_ Gender M or F  
Name of Physician \_\_\_\_\_ Last Exam \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Dentist \_\_\_\_\_ Last Exam \_\_\_\_\_ Phone \_\_\_\_\_  
Check one: Medical Insurance \_\_\_\_\_ Medicaid Insurance \_\_\_\_\_ # \_\_\_\_\_ No Insurance \_\_\_\_\_

**HEALTH INFORMATION**

**Does your child have any *diagnosed* medical or mental health conditions, physical restrictions or limitations needing to be reported to the nurse?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Does he/she take medications regularly?      Yes / No**  
(If yes, please give the name of the medication, dosage, when medication is taken and reason for taking it)  
Medication name \_\_\_\_\_ Dosage \_\_\_\_\_ When taken \_\_\_\_\_ Reason \_\_\_\_\_  
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**Has he/she had a serious illness, concussion, operation or injury needing to be reported to the school nurse?**  
Medical Situation \_\_\_\_\_ Date \_\_\_\_\_  
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Medical Situation \_\_\_\_\_ Date \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_      **Does your child have a *diagnosed* allergy (food or other)?**  
Yes \_\_\_\_\_ No \_\_\_\_\_      **Does your child have an EpiPen?**  
Yes \_\_\_\_\_ No \_\_\_\_\_      **Does your child have *diagnosed* asthma?**  
Yes \_\_\_\_\_ No \_\_\_\_\_      **Does your child have an inhaler?**  
Yes \_\_\_\_\_ No \_\_\_\_\_      **Has your child received any recent immunizations?**

**Other information for School Nurse to have knowledge about:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*If my child has a health problem, the school nurse may use discretion and inform school personnel/health care provider as needed. I/We authorize school officials to obtain medical assistance when necessary for the welfare of my son/daughter if he/she is injured at school/school activity.*

*\*All schools are equipped with pre-filled epinephrine syringes & emergency asthma medication to be administered by the school nurse or designee in the event of a life threatening emergency involving anaphylaxis or asthma.*

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_