

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 _____
Medication name _____ Dosage _____ When taken _____ Reason _____
Medication name _____ Dosage _____ When taken _____ Reason _____

Has he/she had a serious illness, concussion, operation or injury needing to be reported to the school nurse?
Medical Situation _____ Date _____
Medical Situation _____ Date _____
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** _____