West Jasper School District

Student Health History

Please return to the school nurse. This form will be CONFIDENTIAL once received by the nurse.

Student's Name: _____
Birthday: _____ Sex:_____ Grade_____

MOTHER'S NAME _____
PHONE: HOME_____CELL_____WORK_____

FATHER'S NAME _____
PHONE: HOME_____CELL_____WORK_____

EMERGENCY CONTACT OTHER THAN PARENT'S /GUARDIANS:

1._____PHONE : HOME_____CELL_____
2._____PHONE : HOME_____CELL_____
3._____PHONE: HOME_____CELL_____

Health insurance coverage for student (**This information is for funding use only. Parents will not be billed):**

____ Medicaid/MSCAN/CHIPS/Magnolia

____ Blue Cross/State of MS/Other Private Insurance

____ No health insurance coverage

Name of child's primary DOCTOR_____Phone_____

Please list any Medication your child takes on a daily basis:

_____ _____

Does your child require any medications during school hours? Yes_____ No_____

*****IF YOU MARKED YES, YOU MUST COMPLETE THE MEDICATION ADMINISTRATION FORM AND BRING THE MEDICINE (WITH THE PRESCRIPTION LABEL ON IT) OR A PRESCRIPTION FROM THE DR. TO THE SCHOOL NURSE**MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND PROPERLY LABELED WITH STUDENT'S FIRST AND LAST NAME. THIS IS A STATE REQUIREMENT*****

Is your child ALLERGIC to any MEDICINE? NO_____ YES_____ List medication _____
(Describe type of Reaction)_____

Is your child ALLERGIC to any of the following? (**please circle**)

Bee/Wasp Stings Ant /Other Insect Bites Fish/Seafood Peanuts/other nuts Milk Eggs

Describe type of reaction_____

In case of an Allergic Reaction Emergency:
Does your child require an EPIPEN yes____ no_____ or Benadryl yes____ no_____.
Other: (please explain)_____

If your child has a history of Anaphylactic Reaction (Severe Allergic Reaction), the Parent/Guardian is responsible to bring An Epi-pen(in the box with the prescription label on it) or a Doctor's order to the nurse to leave at school. (see "rules for medication at school" in handbook)

Does your child require a special kind of diet? No_____ Yes_____
What type?_____

If your child has a special diet or food allergies, Please provide a Doctor's order for the cafeteria. A new Doctor's Order is required each school year.

*****PARENT ARE RESPONSIBLE FOR INFORMING SCHOOL NURSE/TEACHER'S OF ANY AND ALL ALLERGIES*****

Does your child wear glasses or contacts? Yes_____ No_____

PLEASE FINISH COMPLETING ON PAGE 2 OF THIS FORM

Please **circle** any health conditions your child has or has a history of:

Asthma	Stomach Problems	Seizures	Anxiety/Depression	Bone/Joint Problems
Anemia	Headaches	Nosebleeds	High Blood Pressure	Sickle Cell Trait/Disease
Autism	Hearing Loss	Scoliosis	Speech Problems	Vision Problems
Diabetes	Heart Murmur/Defects		Menstrual Cramps	Birth Defect/Physical Handicap
Attention Deficit Disorder (ADD)				
Attention Deficit Hyperactivity Disorder (ADHD)			Other:_____	

Does your child require an INHALER for ASTHMA while **at school**? _____yes _____no

*****IF YOU MARKED YES, YOU MUST COMPLETE THE MEDICATION ADMINISTRTION FORM AND BRING THE INHALER BOX (WITH THE PRESCRIPTION LABEL ON IT) OR A PRESCRIPTION FROM THE DOCTOR TO THE SCHOOL NURSE** MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND PROPERLY LABELED WIH STUDENT'S FIRST AND LAST NAME. THIS IS A STATE REQUIREMENT*****
*****STATE LAW: SENATE BILL 2363 REQUIRES AN ASTHMA ACTION PLAN FROM YOUR CHILD'S DOCTOR IF THEY REQUIRE MEDICATION FOR ASTHMA WHILE AT SCHOOL*****

Please read carefully:
I UNDERSTAND THE FOLLOWING:

- I am responsible to inform my child's teacher's of any and all allergies and medical conditions that my child has, and/or routine medications that my child takes.
- I understand that my child MAY NOT carry any medications on him/her during school hours UNLESS the doctor order specifies that it is necessary.
- If my child becomes ill or injured at school, I will be notified either in writing or by phone.
- Any suspicious signs of physical or emotional abuse or neglect, by law, will be reported to the Department of Human Services(DHS), Child Welfare Division.
- My child may be screened at school at any time during the school year for scoliosis, vision, weight, head lice and illnesses.
- I give my permission to the SCHOOL NURSE to share and receive information relevant to prescribed medications and medical condition as determined appropriate for my child's Health and Safety.
- I give my permission for the SCHOOL NURSE to administer prescribed medication, assess and intervene for injury and illness, and administer "as needed" (PRN) medications as follows: Tylenol, Ibuprofen, Tums, Benadryl, Chloraseptic Throat Spray, Cough Drops, Antibiotic Ointment, Anti-Itch Cream, Ora-gel, Saline eye drops, and Epi-pens in accordance to the West Jasper School District Standing Orders which have been approved and signed by Dr. Keith Lay Jr., the Voluntary Physician for the West Jasper School District, in the event that my child becomes ill at school. The school nurse does not diagnose, only a qualified physician or nurse practitioner can diagnose.

RELEASE AND INDEMNITY AGREEMENT
I/We forever release, discharge, and covenant to hold harmless the West Jasper School District, its personnel and board of trustees from any and all claims, demands, damages, expense, loss of services and causes of action belonging to my/our child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from administration of medication to my child by qualified school personnel.
I/We agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury to my/our child as a result of administration of medication to my child by qualified school personnel.

_____ _____
Parent or Guardian Signature Date

_____ _____
School Nurse Signature Date Reviewed