

School Health Information Card for Jefferson City Schools

School _____ Grade _____ Teacher _____

Student _____ Male ___ Female ___ DOB _____
Last Name First Name

Address _____

HEALTH HISTORY (ANSWER YES OR NO)

Allergies: (Specify) _____

Physical Handicaps _____ Diabetes _____

Asthma _____ Seizure Disorder _____

Sickle Cell Disease _____ Cancer _____

OTHER PHYSICAL OR MENTAL HEALTH ISSUES WHICH MAY BE A CONCERN AT SCHOOL:

___ Does your child require a special seating in the classroom? Specify _____

___ Does your child have any condition that would limit physical education activities? List _____

___ Does your child take any prescribed medications routinely? List _____

___ Did your child receive any immunizations this past year? List type, date _____

___ Date of last tetanus shot? _____

EMERGENCY CONTACT INFORMATION

Mother/Guardian _____ Phone (Home) _____
Name (Cell) _____
(Work) _____

Father/Guardian _____ Phone (Home) _____
Name (Cell) _____
(Work) _____

If parents cannot be reached, list two nearby persons who will assume care of your child.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Child's Doctor _____ Phone _____

School clinic personnel have my permission to contact my child's physician for further medical information. I also give permission for the school clinic personnel to perform screenings and/or rescreens throughout the year as needed (hearing, vision, and dental). In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the closest hospital. I, the parent/guardian, authorize the transport of and treatment by the hospital emergency staff for my child, _____.

Child's Name

Parent signature _____ Date _____