

Date \_\_\_\_\_

**JEFFERSON COUNTY SCHOOLS  
CLINIC SCHOOL HEALTH FORM**

*Health information within the school is limited to the information necessary to serve the student's educational and health interests.*

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Drug Allergies \_\_\_\_\_

\_\_\_\_\_ My child has no health problems which would affect his/her school day.

\_\_\_\_\_ My child's health needs include the conditions checked.

\_\_\_\_\_ **Allergies:** seasonal \_\_\_\_\_, food \_\_\_\_\_, bees \_\_\_\_\_ (If your child has a known food allergy, the school has to have an order from the physician stating the food allergy and what substitutions or omissions need to be made on your child's tray.)  
Is an EpiPen prescribed? Yes \_\_\_\_\_, No \_\_\_\_\_ (If yes, parent must provide EpiPen)

\_\_\_\_\_ **Asthma:** Is inhaler used? Yes \_\_\_\_\_, No \_\_\_\_\_ If yes, how often? \_\_\_\_\_  
Other medication taken for asthma \_\_\_\_\_

\_\_\_\_\_ **Respiratory** conditions other than asthma: \_\_\_\_\_

\_\_\_\_\_ **Diabetes:** Takes insulin: Yes \_\_\_\_\_, No \_\_\_\_\_ If yes, how often? \_\_\_\_\_  
Other diabetic medications \_\_\_\_\_

\_\_\_\_\_ **Hearing or Vision Problems:** Hearing Aid? \_\_\_\_\_ Glasses? \_\_\_\_\_ Contacts? \_\_\_\_\_

\_\_\_\_\_ **Seizures:** Type \_\_\_\_\_ Date of last seizure \_\_\_\_\_  
Medication taken \_\_\_\_\_

\_\_\_\_\_ **Bleeding Disorders:** Describe \_\_\_\_\_

\_\_\_\_\_ **Heart Problems:** Describe \_\_\_\_\_

\_\_\_\_\_ **Stomach Problems:** Describe \_\_\_\_\_

\_\_\_\_\_ **Kidney Problems:** Describe \_\_\_\_\_

\_\_\_\_\_ **Orthopedic Problems:** Previous Fractures? \_\_\_\_\_ Location \_\_\_\_\_  
Bone/Joint Problems – Describe \_\_\_\_\_

\_\_\_\_\_ **ADD or ADHD** diagnosed? Medication taken \_\_\_\_\_  
Will medication be taken at school? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ **Special Procedures** needed to be performed at school. Describe \_\_\_\_\_

**OVER**

List any other recurrent medical problem or illnesses you would like the school to be aware of.

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If your child is allergic to any of the following, **please circle**. Many of these are often used in the schools for first aid. (Antibiotic ointment/Neosporin, anti-itch cream/hydrocortisone cream, calamine/caladryl lotion, toothache gel (Oragel or Anbesol), alcohol, and peroxide)

In case of emergency, illness, or accident, please list in order of desired action.

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_
3. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_
4. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

If the school is unable to reach one of the above persons, depending on the nature of the emergency, one or all of the following steps may be necessary.

1. Notification to 911. Parents will be expected to pay any accompanying charges.
2. Report to the Department of Human Resources.
3. Report to a law enforcement agency.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Please contact your school personnel for medication forms if your child needs medication at school, including inhalers for asthma or EpiPen for severe allergic reactions. Your child may carry an inhaler if medically authorized (a doctor's note will need to be on file). If your child will receive a procedure such as G-tube feed or diabetic monitoring while at school, an order must be on file before any procedure will be performed.