

Jackson Independent Schools Health Form Update- Completed Annually (1 Per Student)

Medical Information

Student Name: _____
(First Name) (Middle Name) (Last Name)

Physician: _____ Phone: (____) ____--____

Are there any particular medical problems your child may be experiencing? (Please explain.)

- Physical Disabilities _____
- Medicine Allergies _____
- Asthma _____
- Diabetes _____
- Seizures _____
- Epilepsy _____
- Hearing Difficulties _____
- Kidney Problems _____
- Heart Disease _____
- Nervous Disorder _____
- Cancer _____
- Tuberculosis _____
- Other _____

Is this child allergic to any foods? Yes No If yes, please list. _____

Is this child allergic to any medications? Yes No If yes, please list. _____

Is this child allergic to any insects? Yes No If yes, please list. _____

If this child is allergic to anything else that could cause the child harm, please list:

If your child has a severe allergy that could result in anaphylactic shock, we must receive a physician's statement and a sufficient supply of their prescribed medication to be kept at the school for your child's use in the event of an emergency.

Is your child currently on any routine medication? Yes No If yes, please list below:

Medication _____	Dosage _____
Medication _____	Dosage _____
Medication _____	Dosage _____
Medication _____	Dosage _____
Medication _____	Dosage _____

A "Permission Form for Prescribed or Over-the-Counter Medication" (Form 09.2241 AP.21) is available at the school office. This form must be completed for any medication a student will need to take during school hours.

Please attach further information if there is a serious medical issue that we need to be aware of.

Parent Signature

In case of emergency, accident, or serious illness of the above named child, I request the school to contact me. If school personnel are unable to contact me, I hereby authorize them to call the people whom I have placed on my child's emergency contact list. If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.

Parent/Guardian's Name (PLEASE PRINT) _____

Parent/Guardian's Signature _____ Date: _____