Student Information - Please update as needed.

Student Full Name ______ ______ ______
First Middle Last

Date Of Birth ______ Grade Level ______ Gender ______

Birth Certificate on File as Required by Law? Yes ○ No ○ If "No" is selected, please submit as soon as possible

Student Home Number ______
Student Email ______
Student Mobile ______
Student Mailing Address ______
Student Residence Address ______

GUARDIAN NAME ______ ______
Relationship ______ Email Address ______
Guardian: Mailing Address ______
Guardian: Residence Address ______
Home Phone ______ Mobile Phone ______
Work Name ______ Work Phone ______

Emergency Contact ______ ______
Relationship ______
Home Number ______
Mobile Number ______ Work Number ______

Medical Conditions(s) ______

For Food Allergies also complete Page 4

Health Care Provider ______ ______
Office Phone ______ Office Fax ______
Insurance Carrier ______ Group ID # ______
Policy # ______ Plan # ______

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Has your child had or does have any of the following conditions?

Condition	Yes	No
Allergies (food, medication, seasonal, animals, etc)..	☐ Yes	☐ No
Asthma...	☐ Yes	☐ No
Attention Deficit/Hyperactive Disorder.......................	☐ Yes	☐ No
Behavior Problems...	☐ Yes	☐ No
Bladder Problems..	☐ Yes	☐ No
Bowel Problems...	☐ Yes	☐ No
Broken Bones..	☐ Yes	☐ No
Dental Problems..	☐ Yes	☐ No
Diabetes...	☐ Yes	☐ No
Frequent Ear Infections...	☐ Yes	☐ No
Head Injury/Concussion......................	☐ Yes	☐ No
Hearing Impairment/Tubes in Ears.......	☐ Yes	☐ No
Heart Problems/Murmur......................	☐ Yes	☐ No
Hospitalizations..................................	☐ Yes	☐ No
Injuries/Accidents...............................	☐ Yes	☐ No
Mental/Emotional Problems................	☐ Yes	☐ No
Physical Limitations...........................	☐ Yes	☐ No
Seizure Disorder................................	☐ Yes	☐ No
Surgery...	☐ Yes	☐ No
Wears glasses/contacts......................	☐ Yes	☐ No

Please explain "Yes" answers here:

If your child has Asthma, Food Allergies, or Seizures, please see nurse to fill out the appropriate **Action Plan**.

I would like my child's Emergent (inhaler, epi-pen) medication to be: ☐ Stored in the nurses office ☐ Carried on self

Additional information for the school nurse:

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Parental Permission for Medications

Please mark Yes or No if your child can receive the following medications to treat minor illnesses/injuries.

☐ YES ☐ NO **Epi-Pen** For signs/symptoms of severe allergic reaction. (This medication will only be used for an an emergency in which case your child may be unable to breathe due to severe allergic reaction. It could save your child's life.

☐ YES ☐ NO **Benadryl** For signs/symptoms of mild allergic reaction. (liquid and pill form)

☐ YES ☐ NO **Albuterol** For signs/symptoms of asthma attack, wheezing/shortness of breath.

☐ YES ☐ NO **Peroxide** followed by **Triple Antibiotic Ointment** For minor cuts/abrasions.

☐ YES ☐ NO **Hydrocortisone Cream** For minor itching/bug bites.

☐ YES ☐ NO **Aloe Vera Gel** For minor burns/sunburn pain.

☐ YES ☐ NO **Tums/Peppermints** For minor indigestion.

☐ YES ☐ NO **Eye Wash/Sterile Eye Drops** For minor eye irritations.

☐ YES ☐ NO **Vaseline/Carmex** For dry lips.

☐ YES ☐ NO **Orajel** For cold sores/fever blisters/minor mouth sores.

☐ YES ☐ NO **Cough Drops/Butterscotch Hard Candy** For minor throat irritations/cough.

☐ YES ☐ NO **Tylenol(Acetaminophen)** For minor aches/fevers/headache (liquid, chewable, and pill form)

☐ YES ☐ NO **Advil (Ibuprofen)** For minor pain/aches/fever/headache (liquid, chewable, and pill form).

We have received instructions for dosages on all the above medications from Dr. Susan Watson, MD, Mosaic Medical Center, Maryville, MO

☐ The Jefferson C-123 School District has our permission to give the above medications that have been marked YES to our above mentioned child in the case of a minor illness or injury.

☐ I authorize the school and it's employees on my behalf to allow my child to self-administer medication (inhalers) while under the direct supervision of a school employee. I acknowledge that it may be necessary for administration of medications to my child be performed by an individual other than the school nurse, and specifically consent to such practice.

☐ **I DO NOT** give permission for use of any of the above medications on my child.

Student Name: ______________________________

______________________________ Date: ______________________

Name of parent/guardian/other

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Food Allergy Assessment

Do **you think** your child's food allergy may be **life-threatening**? ☐ No ☐ Yes

(If Yes, please contact the school nurse as soon as possible).

Did **your student's health care provider** tell you the food allergy may be **life-threatening**? ☐ No ☐ Yes

(If Yes, please contact the school nurse as soon as possible).

History and Current Status Check the foods that have caused an allergic reaction:

☐ Peanuts ☐ Fish/Shellfish ☐ Eggs

☐ Peanut or Nut Butter ☐ Soy Products ☐ Milk

☐ Peanut or Nut Oil ☐ Tree Nuts (walnuts, almonds, pecans, etc.)

Please list any others: ____________________

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, explain:

____

When was the reaction? ____________________

The food allergies reactions are: ☐ Staying the same ☐ Getting worse ☐ Getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? (*Check all that apply)*

☐ Eat the food ☐ Touch the food ☐ Smell/Inhale the food ☐ Other, please explain:

____

What are the signs/symptoms of your student's allergic reaction? (*Be specific; include things the student might say)*

____

How quickly do the signs/symptoms appear after exposure to the food(s)?

☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Treatment

Has your student ever needed treatment at a clinic or hospital for an allergic reaction? ☐ No ☐ Yes, explain:

Does your student understand how to avoid foods that cause allergic reactions? ☐ No ☐ Yes

What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

____

Have you used the treatment? ☐ No ☐ Yes Does your student know how to use the treatment? ☐ No ☐ Yes

Describe any side effects or problems your child had in using suggested treatment:

____

If you intend for your child to eat school meals, have you filled out a diet order form? ☐ Yes ☐ No

If medication is to be available at school, have you filled out a Medication Order Form? ☐ Yes ☐ No

If medication/treatment is needed at school, have you brought the supplies to the school? ☐ Yes ☐ No

What do you want us to do at school to help your student avoid problem foods?

____

I give consent to share with the classroom, that my child has a life-threatening food allergy. ☐ Yes ☐ No

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VERIFICATION:

In case of illness or injury of my child, I understand the school will attempt to contact parents or guardians first. Then they will contact other people I have listed-who are authorized to receive information, make certain medical decisions, and have my child released to their custody. If none are available, the school is authorized to make whatever arrangements are deemed necessary to maintain my child's health including, but not limited to, emergency treatment.

I am the parent/legal guardian of this child: ☐ Yes ☐ No

If not a legal parent/guardian, state your relationship to the child. ____________________

☐ **I verify the information provided in this document is accurate and current.**

____

Name of parent/guardian/other

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