2022-2023 JESUP COMMUNITY SCHOOL – ANNUAL STUDENT HEALTH HISTORY UPDATE

Name of Student: _____ Birthdate: _____ Grade: _____

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD/ADD/Behavior Issues
- ☐ Asthma: ☐ Inhaler w/ nurse ☐ Self-Carry
- ☐ Autism/Asperger
- ☐ Blood Pressure Problems
- ☐ Diabetes ☐ Type 1 ☐ Type 2
  - ☐ Needs Glucose Monitoring
- ☐ GI Conditions (constipation, reflux, IBS, etc.)
- ☐ Headaches/Migraine
- ☐ Heart Conditions
- ☐ Mental Health Condition (Depression, eating disorder, anxiety)
- ☐ Single Organ: ☐ kidney ☐ testicle
- ☐ Skin Condition
- ☐ Urinary Condition
- ☐ Vision: (glasses/contacts)
- ☐ Other: please list below

Please explain any marked answers: _____

List ALL medications taken, whether given at school or at home. Please attach separate sheet if needed.

Medication	Dosage	How Often	Reason	Given
				☐ Home ☐ School
				☐ Home ☐ School
				☐ Home ☐ School
				☐ Home ☐ School

Please list allergies including food, environmental, latex, and medication allergies.

Allergies:	Reaction	Treatment
		☐ Avoid ☐ Benadryl ☐ Epi Pen ☐ Other:
		☐ Avoid ☐ Benadryl ☐ Epi Pen ☐ Other:

List any special dietary needs/restrictions (allergy to milk, carb counting, increased fiber, or food substitution) – Any special dietary needs ***REQUIRES*** a note from a physician. _____

Explain any serious illness, injury, or surgery that your child has had: _____

Has your child had a: Dental visit in the last year? ☐ Yes ☐ No Dentist's name_____

Physical exam in the last year? ☐ Yes ☐ No Name of child's physician(s) _____

I give permission to the school health staff to share information relevant to my child's health condition with the appropriate school personnel on an as needed basis to meet my child's health and safety needs. ☐ Yes ☐ No

I give permission for my child to receive an Epinephrine Injection if he/she is experiencing symptoms of a life-threatening anaphylactic reaction if deemed necessary by a trained individual. ☐ Yes ☐ No If No, please specify: _____

I give permission to the Jesup Community Schools to give my child a weight appropriate dose of acetaminophen and ibuprofen if deemed necessary by school staff. ☐ Yes ☐ No ☐ Call First

I give permission to the Jesup Community Schools to give my child antacids, cough drops, saline eye drops, and over-the-counter topical ointments (antibiotic ointment, hydrocortisone, Caladryl, lip ointment, antifungal, etc.) if deemed necessary by school staff.
☐ Yes ☐ No If No, please specify: _____

I give permission to the Jesup Community Schools to apply a 'mask' to my child if they are sick with a fever and/or respiratory symptoms.
☐ Yes ☐ No

If a student requires over-the-counter pain medications more than 15 times during the school year, further permission from a healthcare provider will be required before additional doses will be given. No more than 15 doses will be given per year without provider authorization. Any over-the-counter medication that is taken long term at school must have an MD, DO, PA, or ARNP written approval on file at school.

Signature of Parent/Guardian: _____ Date: _____

Emergency Phone: _____ Hospital Preference: _____
If this number changes during the school year, notify the school office immediately.