JESUP COMMUNITY SCHOOL – ANNUAL STUDENT HEALTH HISTORY UPDATE

Name of Student: _____ Birthdate: _____ Gender: _____ Grade: _____

Is your child currently under treatment for: (If any are current diagnoses, please provide an action plan signed by your providers office every year.)

- **Asthma:** ☐ No ☐ Yes - Those who self-carry an inhaler need a consent on file signed by the provider.
- **Diabetes:** ☐ No ☐ Type 1 ☐ Type 2
- **Seizures:** ☐ No ☐ Current ☐ History of ☐ Requires rescue medication
- **Allergies:** ☐ No ☐ Yes: please fill out chart below

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

Please check if your child has been diagnosed by a medical provider for any of the following conditions and provide any additional helpful comments:

Condition	**Comment**	**Condition**	**Comment**
☐ ADHD/ADD/ Behavior Concerns		☐ History of Concussion	
☐ Autism/Asperger		☐ Frequent Headaches/Migraines	
☐ Anxiety ☐ Depression		☐ Heart Condition or blood pressure concerns	
☐ Bleeding or Clotting Disorder		☐ Skin Condition	
☐ Cerebral Palsy		☐ Urinary Condition or kidney disease	
☐ Cystic Fibrosis		☐ Vision: (glasses/contacts)	
☐ GI Conditions (Constipation, reflux, IBS, etc.)		☐ Hearing Concern ☐ Hearing Aides ☐ Cochlear Implant	
☐ Celiac Disease		☐ Other:	

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

Dietary Need/Restriction: ☐ No ☐ Yes:_____ ***REQUIRES A ONE TIME DIET MODIFICATION FORM signed by provider***

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 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 **PLEASE NOTE: If a student requires over-the-counter medications more than 8 times during the school year, further written permission from a healthcare provider will be required before additional doses are given.**

If deemed necessary by school staff, I give permission to the Jesup Community Schools to give my child OTC items such as antacids, cough drops, Vaseline, lotion, saline eye drops, ointments such as hydrocortisone, Benadryl cream, or antibiotic ointment. ____Yes ____No

Signature of Parent/Guardian: _____ Date: _____

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