Student Health Information [redacted]

This card is required for every student, every year. Information will be shared among school staff with a need to know.
Parent is also responsible to notify school personnel regarding student's special needs.

Student Name (Last, First) _____ School _____

Date of Birth _____ Grade / Room _____/ _____ Male Female Student lives with: Mother Father Both □ Other: _____

Parent/Guardian Name:_____ Home phone: _____ Cell phone: _____Relationship to student: _____

2nd Emergency contact Name: _____ Home phone: _____ Cell phone: _____ Relationship to student: _____

Family Translator Name: _____ Phone number: _____ Relationship to student: _____ OK to contact in emergency? YES / NO

Refugee Relocation Agency _____

Health Insurance: □ Medicaid □ CHP+ □ Private □None Dr/Clinic Name/ _____ Phone# : _____

Medication at School: *Two non-prescription medications are available in school for occasional use only. These medications will be administered according to the manufacturer's recommendations. By requesting one of these medications to be given to my student I certify that he/she has no known allergy to the specified product. I understand that if my child needs more than an occasional dose, I will supply the medication for my student's personal use. I authorize administration of this "occasional-use" medication to my child, per policy JLCD-R.*

CHOOSE ONE □ **Ibuprofen** (Advil / Motrin) **OR** □ **Acetaminophen** (Tylenol) **OR** □ **NONE**

(Please use a separate page if necessary to fully describe the child's health conditions. This information is needed for the school nurse to address student's health needs and plan for appropriate care at school)

Vision or Hearing Concerns	**Describe conditions and appliances:** □ hearing aid ___left ___right □ glasses □ contact lenses	**Type of support needed at school:**		
Allergies	**Specify drug, food, insect, other:**	**Describe what happens when exposed**	Medications/ home	**Medications /school**
Asthma	**Date of diagnosis:** **Triggers:**	**Describe signs of illness**	Medications/ home	**Medications /school**
Diabetes	**Date of diagnosis:**	**Describe student's ability to care for self**	Medications/ home	**Medications /school**
Seizures	**Date of diagnosis:** **Date of last seizure:**	**Describe seizures**	Medications/ home	**Medications /school**
Behavioral (ADD, Depression, Emotional Concerns)	**Diagnosis:**	**Type of support needed at school**	Medications/ home	**Medications /school**
Other Health Concerns (History of Head Injury)	**Describe:**	**Medical procedures / equipment**	Medications/ home	**Medications /school**

□ **My child has NO significant health concerns or medications.**

□ **My child rides the school bus.**

Signature of Parent/ Guardian_____ **Print Name** _____ **Date** _____

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