Newton County School District Student Health Record

Student Name_____ Date of Birth_____ Age_____

Male/Female Height (feet / inches)____ /____ Weight(pounds)_____ Grade_____ Teacher_____

Mother_____ Home Phone_____ Cell Phone_____ Work Phone_____

Father_____ Home Phone_____ Cell Phone_____ Work Phone_____

Gaurdian_____ Home Phone_____ Cell Phone_____ Work Phone_____

Mailing Address_____ Email Address_____

In case of an acute illness or emergency, if parent or guardian cannot be reached, the following may be contacted and can pick up student:

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

Primary Physician_____ Phone Number_____

Medical Facility student should be transported to in case of an emergency_____

Medical Insurance: Private_____ Medicaid_____ CHIPS_____Other_____

STUDENT MEDICAL HISTORY

HEALTH PROBLEM	YES	NO	SYMPTOMS RELATED TO THIS HEALTH PROBLEM	TREATMENT USED FOR THIS HEALTH PROBLEM
Allergies to Medications				
Allergies to Food (Allergy Plan Required)				
Allergies to Insect Bites or Stings				
Asthma (Asthma Plan Required)				
Attention Deficit (ADD/ADHD)				
Behavior Disorder				
Birth Defect/Handicap				
Bleeding Disorder (Nosebleeds, Sickle Cell, Hemophilia)				
Bone or Joint Disorder				
Cystic Fibrosis				
Diabetes (Type I / Type II)				
Ear Infections, Hearing Loss, Tubes				
Epilepsy/Seizures (Type_____)				
Headaches, Migraines (Frequency_____)				
Hearing Disorder / Hearing Aids_____				
Heart Condition (Type_____)				
Hypertension (High Blood Pressure)				
Kidney Disorder (Frequent Infections)				
Sinus Problems				
Stomach/Digestive Problems (Frequent Constipation, Diarrhea, Vomiting)				
Speech or Hearing Disorder				
Syncope (Fainting spells)				
Surgery (Please List Surgery & Date				
Vision Disorder / Contacts_____ Glasses_____				
Any Other Medical or Special Need				

PRESCRIPTION MEDICATIONS:

Please list any medication that your child takes on a routine basis that has been prescribed by a physician:

Medication_____Dosage_____Frequency_____Reason_____

Medication_____Dosage_____Frequency_____Reason_____

Medication_____Dosage_____Frequency_____Reason_____

Will your student require any of the above medication at school? _____YES _____NO

(If yes, the parent/guardian and the student's physician will need to complete a Medication Authorization Form. These can be found and printed off the district website health resource link, or at the nurse office.)

OVER-THE-COUNTER (OTC) MEDICATIONS:

The following OTC medicines are included on our physician standing orders and may be administered by the school nurse. Medications administered at school are intended to relieve symptoms until the parent or guardian is able to follow up at home or seek medical treatment. These medications can only be issued once during the school day and not after 2:30 pm. Please indicate yes or no for the medications that may be administered to your child.

OTC Medication	**Yes**	**No**
Tylenol		
Ibuprofen		
Tums		
Cough Drops		
Throat Lozenge		
Chloraseptic Spray		
Eye Drops: Refresh or Visine		
Anti-Itch Topicals: Caladrly or Calagel, Benadryl Gel, Hydrocortisone Cream		
Bactine Spray		
First Aid or Triple Antibiotic Cream		

CONSENTS:

I/we give permission for my/our child to participate in the school's health program which includes health education, basic health screens such as vision, hearing, scoliosis, lice, height/weight, Body Mass Index(BMI). I/we hereby give permission for my child to receive medical examination and treatment for first aid or emergency care by the school nurse or by a trained approved staff member delegated by the school principal or nurse as needed.

_____YES _____NO

I/we give permission for pertinent medical information to be shared between the student's medical provider or pharmacist and the school nurse or approved staff member directly involved with my child at school. I/we hereby give consent for release of pertinent medical records from the student's Healthcare provider as listed above to the school nurse or approved staff member directly involved with my child at school.

_____YES _____NO

Parent/Guardian Signature: _____ Date: _____