JESUP COMMUNITY SCHOOL – ANNUAL STUDENT HEALTH HISTORY UPDATE

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

Is your child currently under treatment for:

- **Asthma:** ☐ No ☐ Yes: (If yes, please provide a copy of an Asthma Action Plan from your provider to the school yearly. Those who self-carry an inhaler need a consent on file from the provider)
- **Diabetes:** ☐ No ☐ Type 1 ☐ Type 2 (Please provide a copy of Diabetes Medical Management Plan from your provider to the school yearly)
- **Seizures:** ☐ No ☐ Yes: (Please provide a copy of the Seizure Action Plan from your provider to the school yearly)
- **Allergies:** ☐ No ☐ Yes: (Any allergy requiring an EPI Pen or high risk for anaphylaxis must have an Allergy Action Plan from your provider yearly)

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

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

If deemed necessary by school staff, I give permission to the Jesup Community Schools to give my child: check all that apply
☐ antacids ☐ cough drops ☐ saline eye drops ☐ Vaseline/Lotion ☐ Over the counter ointment (hydrocortisone, Benadryl cream or antibiotic oint.)

Signature of Parent/Guardian: _____ Date: _____

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

Revised 3/22/2023