RAYMOND SCHOOL DISTRICT **JLCE-R**

CONFIDENTIAL STUDENT INFORMATION FOR NURSE'S OFFICE

TO BE RESCINDED

NAME:_____ GRADE:_____ DOB:_____

PARENT/GUARDIAN:_____

ADDRESS:_____

Your child primarily lives with (circle one) Both Parents / Mom / Dad / Other_____

Primary Doctor:_____ Phone:_____ Hospital for emergencies:_____

Last physical date:_____ (copy needed in nurse's office for sports and files)

Did your child receive any immunizations recently?_____
Please forward information and dates to the nurse's office.
Has your child had Chicken Pox or been vaccinated for Chicken Pox?_____
If yes, please forward the date of vaccine or disease to the nurse's office.

Does your child have any allergies to medication? (circle one) Yes No
(If "yes", please list and document reactions.)

1._____

2._____

Any other allergies: (bee stings, peanuts/nuts, dairy, seasonal, food, environmental, etc.)

_____ Reactions:_____

Current treatment used at home:_____

Special diet or classroom considerations: (no sugar, no soda, etc.)_____

_____

Pertinent medical information: (check any that apply)

____ Heart Disease/Murmur
____ Frequent Ear Infections
____ Seizures
____ Frequent Headaches
____ Diabetes
____ Kidney/Bladder Concerns
____ Nose Bleeds
____ Migraines
____ Asthma (Inhaler? Yes / No)
____ ADD/ADHD (circle one)
____ Contacts/Glasses (circle one)
____ Menstrual Problems
____ Insect Bite Reactions
____ Frequent Sore Throat
____ Intestinal Problems
____ Dizziness/Fainting
____ Recent Mononucleosis
____ Other

Please explain any special health concerns for items that were checked above:

_____

_____

_____

(continued on reverse)

IN SCHOOL MEDICATION:

If necessary, I give permission for the school nurse to give my child the following medications:

____ **Tylenol 325mg tab (1 or 2 tabs) or liquid (weight appropriate dosage)**
____ **Ibuprofen (Advil) 200 mg tab (1 or 2 tabs) or liquid (weight appropriate dosage)**
If your child needs chewable tabs, please bring in a supply for your child.
Chewable tabs are not stocked in the nurse's office.
____ **Tums**
____ **Cough drops/ throat lozenges**

*******I understand that if my child needs these medications frequently, I will need to bring in a supply for my child. Any and all medications will be kept in the nurse's office.

Parent/Guardian Signature:_____ **Date:**_____

Please list **any medications that your child takes during the day at home** and include dosages:
(This alerts us to possible side effects to watch out for.)
_____ Dose_____
_____ Dose_____
_____ Dose_____

EMERGENCY INFORMATION

Father's Name_____
Home Phone _____
Cell Phone_____
Work Phone_____
Work Address_____
_____
_____

Mother's Name_____
Home Phone _____
Cell Phone_____
Work Phone_____
Work Address_____
_____
_____

Please list 2 people who may assume responsibility for your sick/injured child and who can pick your child up from school if we are unable to contact you.

Name_____
Address _____
Phone_____

Name_____
Address _____
Phone_____

My child usually:
_____ Walks Home
_____ Takes Bus
_____ Is Picked Up

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Information may need to be exchanged between the nurse's office and the physician's office regarding immunizations, physical dates, or for emergency purposes.

I **give** / **do not give** *(please circle one)* permission for the nurse's office and the physician's office to exchange the above information.

Doctor's Name_____

Telephone_____

Parent Signature:_____

Adopted: August 1, 2002
Revised: June 2, 2010