School Year: 20____ - 20____

Teacher Name _____

Grade _____

JACKSON-MADISON COUNTY SCHOOLS MEDICAL AND EMERGENCY INFORMATION AND AUTHORIZATION

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR CHILD:

Name: _____ Date of Birth: _____

SSN: _____ Home Phone: _____

Address: _____ Child's Medical Doctor: _____

_____ Doctor's Phone: _____

Health Ins. Company: _____ Insurance Policy #: _____

PLEASE ANSWER THE FOLLOWING REGARDING THE CHILD'S PARENT(S) OR LEGAL GUARDIAN(S)

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

Employer: _____ Employer: _____

Work Address: _____ Work Address: _____

Work / Cell Phone: _____ Work / Cell Phone: _____

In case of accident, injury or other emergency in which the parents cannot be reached, please identify two additional adults who have authority to act with regard to transportation or other urgent needs.

Name: _____ Name: _____

Relationship to child: _____ Relationship to child: _____

Home Phone: _____ Home Phone: _____

Work / Cell phone: _____ Work / Cell phone: _____

PLEASE DESCRIBE YOUR CHILD'S HEALTH HISTORY: (check all that apply and give explanations below)

☐ **ALLERGIES (please list):**

- ◯ Food _____
- ◯ Medication _____
- ◯ Insects _____
- ◯ Other _____
- ◯ Does your child's allergic reaction require an Epi-pen (shot)? ◯ Yes ◯ No

☐ **ASTHMA**

- ◯ Does your child have an inhaler? ◯ Yes ◯ No **WHAT KIND**? _____
- ◯ Will your child be carrying or keeping an inhaler at school? ◯ Yes ◯ No
- ◯ Does your child have a nebulizer (breathing machine) at home? ◯ Yes ◯ No
- ◯ Recent hospitalization / ER visit (reason/date) _____

☐ **ADDITIONAL CONDITIONS:**

◯ ADD/ADHD	◯ Earaches	◯ Psoriasis
◯ Autism	◯ Eczema	◯ Seizures/Date of last _____
◯ Bladder problems	◯ Heart problems	◯ Sickle cell
◯ Blood disorder	◯ Hemophilia	◯ Spina Bifida
◯ Bowel problems	◯ Kidney disease	◯ Vision Impaired
◯ Cancer/Leukemia	◯ Migraines	◯ Wears: glasses _____ contacts _____
◯ Cerebral Palsy	◯ Nosebleeds	◯ Wears hearing aid _____
◯ Cystic Fibrosis	◯ Pneumonia/Date _____	◯ Weight problems
◯ Diabetes	◯ Premature birth	◯ Other _____

◯ Recent Hospitalizations _____ ◯ Past Surgeries _____

_____ _____

_____ _____

- over -

Child's Name:_____

JACKSON-MADISON COUNTY SCHOOLS
MEDICAL AND EMERGENCY INFORMATION AND AUTHORIZATION

Other medical conditions or disorders not listed on page 1:_____

_____

_____

_____

Date of last physical exam: _____

List all medications taken (including frequency and dosage):

At home: _____

_____

_____

At school: _____

_____

_____

Additional Information (such as diet restrictions, physical limitations, etc.): _____

_____

_____

_____

In the event I cannot be reached immediately in the case of an accident or injury, I authorize that medical treatment may be given and that my child may be transported to a medical facility for the purpose of receiving immediate medical attention.

I also authorize Jackson-Madison County School System, its agents and employees, to release any of my child's health information to the medical providers rendering care. I understand that I will be responsible for any expenses associated with the medical treatment and/or medical transportation that my child receives.

I also authorize the sharing of this information with my child's teachers and other school personnel as needed.

Parent/Legal Guardian Signature:_____

Date: _____