Jefferson County
School District 509J
UNITE. ENGAGE. SOAR.

Student Medical Information

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

Home Address: _____

Parent/Guardian: _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____

Name of Physician: _____ **Physician Phone:** _____

Medical Insurance Provider: _____

ID Number: _____ **Group Number:** _____

HEALTH HISTORY

Allergies (Check all that apply and briefly describe)

- ❑ Insect stings/bites: _____
- ❑ Environmental: _____
- ❑ Food: _____
- ❑ Medications: _____

Past Medical History (Please check if student has previously had or currently has any of the following and briefly describe if necessary)

Condition	Previous	Current	Additional Information
Asthma			
Bleeding/Clotting Disorders			
Diabetes			
Epilepsy			
Heart Defect/Disease			
Hypertension (High Blood Pressure)			
Other:			

Does your student have any physical activity restrictions? YES NO

If yes, please explain: _____

_____

_____

(continued on reverse)

Does your student have any dietary restrictions? YES NO

If yes, please explain: _____

_____

_____

Medications

Please list all medications the student takes, including prescription and over-the-counter.

Medication	Dose	Route	Instructions

Other pertinent information or health concerns: _____

_____

_____

_____

_____

_____

_____

_____

I hereby give my consent to Jefferson County School District 509-J to authorize any emergency medical treatment by a licensed health care provider in the event of illness or injury of my student during the 2020-2021 school year. Furthermore, I consent for the release of medical information to be shared between medical providers, the faculty of Jefferson County School District 509-J, and school chaperones only as needed to maintain my student's health and safety.

_____ _____

Parent/Guardian Signature Date