LEAKE COUNTYSCHOOL DISTRICT
MEDICAL INFORMATION SHEET

Student's Name* _____ Grade* _____

Date of birth* _____ Age* _____ Check one:* ☐ Female ☐ Male

CONTACT INFORMATION: It is of utmost importance that we have current and accurate contact information and phone numbers. Any changes need to be reported to the office and nurses as soon as possible. If an emergency arises, and we are unable to reach you or your emergency contacts, the school district reserves the right to contact the Mississippi Department of Human Services for further assistance.

NAME	DAYTIME PHONE NUMBER	RELATIONSHIP

Please list any siblings also at Leake Middle School and what grade they are in:

Allergies?

☐ Food ☐ Plants ☐ Insect bites/stings ☐ Medications ☐ No known allergies	Please explain any allergies and the type of reaction your child might experience if accidentally exposed to an allergen:

Administering Over-the-Counter meds

School personnel will not be permitted to administer any type of medication to students in my absence. Please read the following list of medications that are used in the nurse's clinic.

Choose any medicines that you **WANT ADMINISTERED TO YOUR CHILD.** **Submission of this form will indicate that only the medications selected may be administered to your child as needed by the nurse**:

Choose the medications that you **DO** want to be given to your child:*

- ☐ Cough drops
- ☐ Caladryl
- ☐ Tylenol
- ☐ First Aid Spray/Ointment
- ☐ Triple Antibiotic Ointment
- ☐ Chloraseptic Spray (Sore throat)
- ☐ Anti-itch cream
- ☐ Pepto-Bismol (upset stomach)
- ☐ Antifungal cream (ringworm

Is the student on a daily medication?*	☐ Yes	☐ No

MEDICATIONS If yes, please list the name, dosage, and how often the student takes the medication each day. (i.e. metformin, 200 mg, 2 times a day) ***ASTHMA INHALER–If your child uses an inhaler, please send an extra inhaler to be used as needed.**

STUDENT MEDICAL HISTORY

Has (or does) your child ever had any of the following health problems/illnesses now or in the past?*	Yes	No	If the answer is YES, please explain.
Allergies to drugs/medications			
Allergies to foods			
Allergies to insect bites			
Seasonal allergies			
Asthma			
Birth defects			
Bone or joint problems			
Chicken pox			
Convulsions/Seizures			
Diabetes/high blood sugar			
Handicap (physical)			
Headaches (frequent or needing prescribed medication)			
High Blood Pressure			
Nerve problems			
Rheumatic Fever			
Sight/Vision problems			
Speech problems			
Stomach or digestive problems			
Surgery			
History of serious injury from an accident?			
Other Health problems not listed above			

Describe any additional special needs:

PRIMARY CARE PROVIDER

Children with chronic conditions will need a doctor's statement regarding treatment at school. You will be notified if your child complains of the same ailment five times. A doctor's visit will then be required before the student can return to classes. Please give us the contact information of your regular physician to help in this process:

Primary Care Physician's Name, Clinic, and Phone Number*
_____ (_____)_____

PARENTAL AGREEMENT OF CARE STATEMENT

- In case of emergency, I realize my student will be transferred to Baptist-Leake Hospital Emergency Room.
- I hereby give permission for my child to participate in the school's health program and receive first aid care and health education from the school nurse.

Parent/Guardian Name (printed) _____ Signature _____

Date: _____

If you have any questions or need our assistance in any health matters, please feel free to call me at 601.267.7713. It is my goal to help maintain the same standard of good health for your child while he/she is at school that you do for him/her at home.

Lynda K Pickett RN, BSN
School Nurse, Leake Central Junior High