HEALTH CARD (please answer all questions) SCHOOL YEAR:_____

Grade: _____

Name:_____ Male/Female Teacher:_____

(Last) (First) (MI) (circle one)

Social Security Number:_____ Date of Birth_____Medicaid or ARKids#_____

Address: _____

Parent/Guardian Name(s):_____ Home Phone Number:_____

Authorized Emergency Contact:_____ Phone:_____Relationship:_____

Authorized Emergency Contact:_____ Phone:_____Relationship:_____

Physician's Name:_____Phone:_____

Do you have health insurance*?* Yes/No Does your child ride a bus*? Yes/No*

Does your student have a ***current*** medical diagnosis of any of the following conditions? (Check all that apply)

__ASTHMA __ ADD/ADHD __Wear Contacts/ Glasses

__Diabetes __Blood Disorder __Hearing Loss Right_Left_ Hearing Aid

__Heart Condition __Cerebral Palsy __Allergic To Medications

__Seizures __Kidney Disorder __ Other (specify):_____

Severe or Life-Threatening Allergy to Nuts,Latex, or Stings (specify)_____

What medication(s) is your child currently taking*?*_____

Will your child need to take medication or inhalar at school? (if so please bist name and dose):

_____

_____

I acknowledge that the Jonesboro Public School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent

I will notify the school of any change in address, phone number, emergency contact or my child's health status. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for iny child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child..

In compliance with the Family Education Rights and Privacy Act (FERPA) (20U.S.C. & 1232g; 34 CFR Part 99). I give permission for my child's personally identifiable information/student education records to be disclosed to ISEP for the purpose of billing Medicaid and/or private insurance,

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C.1232g; 34 CFR Part 99) I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.

Date:_____ Signature of Parent/Guardian: _____