NORTH PANOLA SCHOOL DISTRICT

Central Office
470 Hwy 51 North Sardis, MS 38666
Phone: (662) 487-2305 Fax: (662) 487-2050
Cedric Richardson, Superintendent
"Providing a Quality Education for All Students"

HEALTH INFORMATION
2020-2021

Student Name:_____ Student's Birthdate: _____

Teacher: _____ School: _____ Grade: _____

The following information is considered confidential and is for use of teachers, principal, school nurse/health staff, or other staff who will be in contact with and responsible for your child during the school day. If you prefer talking personally to the school nurse/health staff regarding any of the following statements, please mark here_____ and she will contact you. Home: _____ Work:_____ Signature:_____

CHECK ANY OF THESE CONDITIONS WHICH YOUR CHILD HAS:

_____ Cancer	**_____ Kidney/Bladder Disease**	**_____ Vision Problems**	**_____ ADD**
_____ Diabetes	**_____ Convulsions/Seizures**	**_____ Hearing Problems**	**_____ ADHD**
_____ Heart Disease	**_____ Orthopedic/Bone**	**_____ Social/Emotional/Behavioral Concerns**	
_____ Autism	**_____ Bowel Concerns**	**_____ In Counseling**	

____Allergy To: _____ Severe Yes ____ No ____

____Asthma Provoked by: _____ Severe Yes ___ No ____

Do you have medical insurance? Yes_____ No _____ What kind? _____
Has above condition been diagnosed by a medical doctor? Yes_____ No_____
If yes, what is the name of the doctor?_____ Phone #: ( ) _____
May we obtain this information? Yes____ No____ If yes please sign a release of information obtained from the school nurse.
What does the student do to manage their own condition? _____
_____

How can we help with this at school? _____
_____

What symptoms should we report to you? _____
_____

Take Medication Daily at _____ Home _____ School
Medication is: _____
For: _____

IF YOUR CHILD MUST RECEIVE MEDICATION WHILE AT SCHOOL, AN "AUTHORIZATION FOR MEDICATION" FORM MUST BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN AND PARENT(S) OR LEGAL GUARDIAN(S) BEFORE MEDICATION CAN BE GIVEN. YOU CAN OBTAIN THESE FORMS FROM THE SCHOOL SECRETARY OR SCHOOL NURSE.

Please provide information not included above which you think we should know about your child's physical, mental, and emotional health which might affect their school performance or require special consideration (i.e., limitation in activities, etc).

_____
_____

Parent Signature:_____ Date:_____