Newton County School System

Student Registration Packet

CLINIC INFORMATION CARD

Gender: ___Male ___Female Student's Name: ______________________________
Last First

Date of Birth: ____|____|______ Grade ____ HmRm Teacher ______________________
mm dd yyyy

Name of siblings enrolled in this school: ______________________________

HEALTH HISTORY (If yes, please explain)

___Yes ___No	Allergies (LIST ALL)	___Yes ___No	Kidney Problem
___Yes ___No	Asthma	___Yes ___No	Migraine Headache
___Yes ___No	Cancer	___Yes ___No	Physical Handicaps
___Yes ___No	Diabetes	___Yes ___No	Skin Condition
___Yes ___No	Seizure	___Yes ___No	Heart Problems
___Yes ___No	Menstrual		
___Yes ___No	Drug Allergies/Reaction		
___Yes ___No	Other		
___Yes ___No	My child needs an inhaler/nebulizer available at school (if YES, provide medication to keep at school)		
___Yes ___No	My child requires an Epi-Pen for severe allergic reaction (if YES, provide Epi-Pen to keep at school)		
___Yes ___No	My child received immunizations this past year If YES list type and date:		
___Yes ___No	My child takes prescribed medications routinely/occasionally If YES please list:		

EMERGENCY INFORMATION

Parent/Guardian #1: ______________________ Relationship to Student: ______________
Residence Ph: ______________ Work Ph: ______________ Cell Ph: ______________

Parent/Guardian #2: ______________________ Relationship to Student: ______________
Residence Ph: ______________ Work Ph: ______________ Cell Ph: ______________

If parents cannot be reached, list two (2) Emergency Contacts who will assume care of your child:
Emerg.Contact #1: ______________________ Relationship ____________ Ph: __________
Emerg.Contact #2: ______________________ Relationship ____________ Ph: __________

Please Note	In the event that Emergency Medical care is deemed necessary, the school will immediately attempt to make contact using phone numbers provided on the clinic card and will contact Emergency Medical Services (911) to respond to the school for evaluation and possible transport.
___Yes ___No	Medical information, as indicated above, may be shared with appropriate staff as needed.
___Yes ___No	In an **emergency**, I give the principal, or designee, permission to administer Tylenol or Benadryl in the event the parent or contact person cannot be reached.
___Yes ___No	In non-emergency health concerns I authorize the school nurse/school personnel to utilize the following medications: anti-itch medication (caladryl, cortisone cream/lotion), antiseptic sprays, cough drops or the generic of these. I understand that it is the **parents'** responsibility to provide non-prescription medications to have available at school such as Motrin, Tylenol, Benadryl, etc. All medication must be labeled and **must be** in the original container. School Nurses are prohibited by their license restrictions to dispense prescription medication without the prescribing doctor's signature.

Should there be a need for school personnel to dispense prescription/nonprescription medication to my child, I will contact the school for the appropriate medication form that must accompany medication. I understand that **all medication must be provided by the parent/guardian** and that no personnel can dispense without parent/guardian signature.

Parent/Legal Guardian Signature

Date

Child's Name:________________ Teacher:________________

Date/Time	Reason for Clinic visit/Complaint------Action Taken	C/H