Rankin County School District
TRADITION OF EXCELLENCE

RANKIN COUNTY SCHOOL DISTRICT
STUDENT HEALTH RECORD

Student Name: _____ Grade: _____ Male ❑ Female ❑

Date of Birth: _____ Age: _____ Height (Feet / Inches): _____'/_____" Weight (lbs): _____

Parent / Guardian: _____ Address: _____

Cell #: _____ Home #: _____ Work#: _____ E-Mail: _____

Medicaid #: _____ Health Ins.: _____

Student's Healthcare Provider: _____ Phone #: _____ Fax: _____

Student's Medical History

ASTHMA

Does your child have asthma? Yes ❑ No ❑ If yes, mark one: Mild ❑ Moderate ❑ Severe ❑

An *Asthma Plan* is REQUIRED to be to be on file at the school for all students with asthma.

FOOD ALLERGIES

Does your child have food allergies? Yes ❑ No ❑ If yes, please list foods allergic to and reactions below.

_____

_____

LIFE THREATENING ALLERGIES TO INSECT BITES

Does your child have life threating allergies to insect bites? Yes ❑ No ❑ If yes, list insects:

_____

_____

All students with food and or insect allergies need an *Allergy Plan* on file at the school.

EPILEPSY / SEIZURES

Does your child have Epilepsy or seizures? Yes ❑ No ❑ If yes, your child needs an *Epilepsy / Seizure Plan* on file at the school.

CONTINUED ON NEXT PAGE

DIABETES

Does your child have Diabetes? Yes ❑ No ❑ If yes, your child needs a Diabetes plan on file at the school.

Does your child have an insulin pump? Yes ❑ No ❑

EMERGENCY MEDICATIONS

Epipen: ❑ Rescue Inhaler: ❑ Diastat: ❑ Glucagon: ❑ None of These: ❑

DAILY MEDICATIONS

Is the student taking any daily prescription or OTC medication at home? Yes ❑ No ❑ If yes, please list below.

Will the student need to take medication daily at school? Yes ❑ No ❑

If your child has daily and / or emergency medications at school, each will need a Medication Consent Form (signed by a physician) to be on file in the school office. You are responsible for supplying the medication.

OTHER

Is there anything else related to a diagnosed medical condition that you feel the school should know about your child?

CONSENT

The undersigned parent or guardian understands, acknowledges and agrees that state or county employed Region 8 health care support service professionals / counselors will or may be providing counseling and / or health care services to all ages of RCSD students in addition to the health care / counseling services for students traditionally provided by employees, nurses and counselors of the Rankin County School District, and hereby consents to such proposed or provided services as may in the sole discretion of the school district or health care providers be necessary or desirable while my child (children) is in the care of the school district.

Yes ❑ No ❑

For Middle / High School Students Only: I give consent for my child to participate in suicide prevention screening conducted by Region 8.

View Screener Here

Yes ❑ No ❑

Parent/Guardian Signature: _____ Date: _____