Tishomingo County School District
Student Health Record 2025-2026

Student: _____ **Grade:** _____ **Teacher/ Homeroom:** _____

Does your child have any of the health conditions listed below?
(***Please only mark what applies to your child***)

☐ **Male**

☐ **Female**

☐ **ALLERGIES** *Please list allergies below: ☐ **No Known Allergies**

_____

_____

_____

_____

Are any of the allergies above severe allergies requiring the use of an EpiPen and/or other medications? Yes_____ No_____

★ *If yes, the* ***Allergy Emergency Treatment Plan will need to be completed by you and your child's Physician.*** *Also, food allergies require the* ***Medical Statement Non-Disabled Child*** *form for needed adjustments in the school nutrition program.*

★*Please note that in accordance with the Americans with Disabilities Act service dogs will be allowed on all TCSD campuses to assist children with medical conditions or disabilities.*

☐ **SURGICAL HISTORY**

_____

_____

_____

_____

_____

☐ **ASTHMA** (***current*** *diagnosis*)

- If so, does your child use an inhaler? Yes_____ No_____
- Will your child need his/ her inhaler at school? Yes_____ No _____
- Asthma medications used:
  _____

  _____

★*In accordance with S.B. 2218 "MS Asthma and Anaphylaxis Child Safety Act" ALL students with asthma are required to have a current* ***Asthma Action Plan*** *on file that has been completed by the child's physician.*

☐ **SEIZURES**

- If so, does your child use seizure medication? Yes_____ No_____
- Seizure medications used:
  _____

  _____
- Will medication need to be given at school? Yes_____ No_____

★ *If yes, the* ***Authorization for Medications at School*** *form will need to be completed by you and your child's Physician.*

- Is emergency medication prescribed? Yes_____ No_____

★ ***Seizure Care Plan*** *is required.*

☐ **HEART CONDITIONS**

- Current diagnosis:_____

  _____

  _____
- Medications for condition:_____

  _____

  _____
- Will medication need to be given at school? Yes_____ No_____

☐ **DIABETES** ☐ **Type 1** ☐ **Type 2**

- If so, does your child use insulin? Yes_____ No_____
- Insulin pump? Yes_____ No_____
- Continuous glucose meter? Yes____ No_____
- Oral diabetic medications used:

_____

_____

★ ***Diabetes Medical Management Plan*** *will need to be completed.*

☐ **ADHD**

- If so, does your child take medication? Yes_____ No_____
- ADHD medications used:

_____

_____

- Will medications need to be given at school? Yes____ No ____

★ *If yes, the* ***Authorization for Medications at School*** *form will need to be completed by you and your child's Physician.*

☐ **STOMACH CONDITIONS**

- Current diagnosis:_____

_____

_____

- Medications for condition:_____

_____

_____

- Will medication need to be given at school? Yes____ No____

Please check if any of the following conditions apply.

☐**History of head injury**

☐**Hearing problems**

☐**Vision Problems**

☐**Dental problems**

☐**Eating disorder**

☐**Muscle/bone problems**

☐**Sickle Cell disease**

☐**Bleeding disorder**

☐**Kidney disease**

☐**Bladder problems**

☐**Nosebleeds**

☐**Cystic fibrosis**

☐**Migraines**

☐**Depression**

☐**Anxiety**

☐ **Behavioral concerns**

***School counselors will be notified accordingly for mental health concerns.**

☐ **None of the above apply to my child**

☐ **Does your child see a specialist? Please list the name and contact number for them.**

☐ **Are there any other conditions the school nurse needs to know about to care for your child?**	☐ **Are there any other medications your child takes regularly or as needed that are not listed above?**

Tishomingo County School District

Medical Policy and Consent Form 2025-2026

Student: _____ Birthday: _____Grade: _____Teacher:_____

Parent/ Legal Guardian Contact Information

Mother/Guardian: _____ Father/Guardian_____
Employer_____ Employer_____
Main phone_____ Main phone_____
Work phone_____ Work phone_____
Email_____ Email_____

If unable to reach parent/ guardian contact:

	Name	Relationship to Student	Phone
1.			
2.			
3.			

Child's Physician: _____ Phone: _____

"Over-the-counter" medications are available from the school nurse only if a standing order form is completed and on file from a physician. Over the counter medications will not be given before 10:00 a.m. or after 2:00 p.m. If medications are needed, the school nurse will call for you to bring medication and continue to monitor your child as necessary.. Students *are not* allowed to bring medications to school or keep any medications with them at school (Exception- see below*). If your child requires prescription medications or other medications not available from the nurse, you and your child's physician *must* complete the *Authorization for Medication at School* form. All**

medications must be brought to school by parent/guardian in the original pharmacy container. (Pharmacists will provide an extra container if requested)

X_____ _____

Parent/ Legal Guardian Signature Date

**Students may keep Asthma Inhalers, Diabetic Medications/ Supplies, and Epi-Pens with them at all times if so ordered by the attending physician. If so, you and your child's physician must complete the required form and/ or care plan related to your child's specific diagnosis listed above. All of this required paperwork must be returned to the school nurse to be kept on file in the student's school health record. If you have any questions, please contact the school nurse.*

**In accordance with the "MS Asthma and Anaphylaxis Child Safety Act" Tishomingo County School District will maintain a supply of auto-injectable epinephrine (EpiPen) at each school to be administered to a student when the school nurse or trained school employee, in good faith, believes is having an anaphylactic reaction, whether or not the student has a prescription for epinephrine.*

By signing this form, I give consent for my child to receive medical care/treatment, medication administration, first aid, or other needed emergency intervention by school personnel. In the event of an *extreme* emergency requiring an ambulance, I understand I am responsible for costs incurred. I also acknowledge that I have read and understand all statements on this form regarding medication administration, including emergency EpiPen administration, at school and required forms to be turned in to the school nurse. I understand that I am responsible for turning any required forms needed into the school nurse. I also give my permission for my child to have health screenings including hearing, vision, height, weight, blood pressure, and scoliosis. (Head lice screenings are not optional and will be done periodically throughout the school year.)

X_____ _____

Parent/ Legal Guardian Signature Date