



ALABAMA STATE DEPARTMENT OF EDUCATION
HEALTH ASSESSMENT for School Year: 2025-2026
Also, downloadable on the JCS District Website



To Parent or Guardian:

The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept strictly confidential.

PLEASE complete both pages of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)			Birth Date	Sex	School
Address (Street)					
Home Telephone Number	Cell Telephone Number	Additional Phone Number		Grade	Teacher/Homeroom
Name of Parent/Guardian (Last, First, Middle)				Work Phone Number	
Transportation <input type="checkbox"/> Bus Rider Bus Number <input type="checkbox"/> Car Rider <input type="checkbox"/> Special Needs Bus <input type="checkbox"/> After School					

Part I – Health Information

Place where your child receives regular health care:

Physician's Name: _____

Address: _____

Telephone: _____

- Community Health Center
- Health Department
- Hospital Clinic
- No Regular Place
- Private Doctor/HMO

Preferred Hospital: _____

Your child's Insurance Information:

- ALL KIDS
- Medicaid
- No Insurance
- Other _____
- Private Insurance _____

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Telephone: _____

- Community Health Center
- Health Department
- Hospital Clinic
- No Regular Place
- Private Dentist/HMO

Part II – Medical History Medical Equipment/Procedures Required at School

<input type="checkbox"/> Catheter	<input type="checkbox"/> Gastric Tube	<input type="checkbox"/> Nebulizer Treatments	<input type="checkbox"/> Oxygen Supplement	<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Vagal Nerve Stimulator (VNS)	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker	
<input type="checkbox"/> Other <i>Please explain:</i>				

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure). Please see your school nurse.

Please Complete Form on Next Page (Signature Required)



ALABAMA STATE DEPARTMENT OF EDUCATION
HEALTH ASSESSMENT for School Year: 2025-2026



Name of Student: _____ **Part III – Medical History**

<input type="checkbox"/> YES <input type="checkbox"/> NO	KNOWN HEALTH PROBLEMS If NO, go directly to the bottom of the page and provide parent/guardian signature If YES, and diagnosed by a physician, answer each question below.
<input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Disorder (ADD)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Hyperactivity Disorder (ADHD) Requires medication? <input type="checkbox"/> At school <input type="checkbox"/> At Home
<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies: <input type="checkbox"/> Hives/rash <input type="checkbox"/> Medications <input type="checkbox"/> Other <input type="checkbox"/> Food _____ <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Epi-pen <input type="checkbox"/> Insects _____ <input type="checkbox"/> Environmental _____ <input type="checkbox"/> Medications _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma <input type="checkbox"/> Uses an inhaler at school <input type="checkbox"/> Uses an inhaler at home
<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood/Bleeding Problems: <input type="checkbox"/> Hemophilia <input type="checkbox"/> Von Willebrand's <input type="checkbox"/> Other <input type="checkbox"/> Requires medication <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Nose Bleeds: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer/Leukemia: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cystic Fibrosis: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Monitors Blood Sugars at school <input type="checkbox"/> Requires Insulin at school <input type="checkbox"/> Insulin pump <input type="checkbox"/> Glucagon order <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Managed with diet <input type="checkbox"/> Oral medication
<input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional/Behavioral/Psychological: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal/Stomach Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Genetic / Rare Disorders: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing Problems: <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both ears <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aid <input type="checkbox"/> Cochlear Implant
<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Conditions: <input type="checkbox"/> Activity restrictions: <input type="checkbox"/> Medications taken at home: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension (High Blood Pressure): <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney/Bladder/Urinary Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Scoliosis: <input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Family History
<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures/Convulsions: Type of seizure: _____ Medications: <input type="checkbox"/> Diastat <input type="checkbox"/> Klonopin <input type="checkbox"/> Versed <input type="checkbox"/> Medication taken at home <input type="checkbox"/> Other _____ <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell: <input type="checkbox"/> Anemia <input type="checkbox"/> Trait
<input type="checkbox"/> YES <input type="checkbox"/> NO	Shunt: <input type="checkbox"/> VP shunt <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida:
<input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Vision Problems: <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Conditions: <i>Please include <u>any</u> medications taken at home only.</i>

Required Signatures

Parent(s) or Guardian Signature: _____	Date: _____
School Nurse Signature: _____	Date: _____

Please complete this form and return to the school office.



ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year _____ - _____

STUDENT INFORMATION

Student's Name: _____ School: _____
Date of Birth: _____ Age: _____ Grade: _____ Teacher: _____
_____ No known drug allergies _____ Allergies (please list) _____

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ Dosage: _____ Route: _____
Frequency/Time(s) to be given: _____ Start Date: _____ Stop Date: _____
Reason for taking medication: _____
Potential side effects/contraindications/adverse reactions: _____
Treatment order in the event of adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No

Is self-medication permitted and recommended? Yes No

- If "yes" I hereby affirm this student has been instructed on the proper self-administration of the prescribed medication.

Do you recommend this medication be kept "on person" by student? Yes No

Cake Icing Gel ONLY FOR Diabetic Student during Bus Transportation? Yes No

Printed Name of Licensed Healthcare Provider: _____

Phone: () _____ - _____ Fax: () _____ - _____

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the school Nurse, the registered nurse (RN) or licensed practical nurse (LPN), to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with the School Nurse or Trained Medication Assistant.

Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be presented to the School Nurse or Trained Medication Assistant. OTCs must be in the original, unopened, and sealed container. **OTC medication may not be kept for more than 2 weeks without written authorization from an authorized licensed healthcare provider.** Local Education Agency Policy for OTC medication must be followed.

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized for complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____



ALABAMA STATE DEPARTMENT OF EDUCATION
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year _____ - _____

STUDENT INFORMATION

Student's Name: _____ School: _____

Date of Birth: _____ Age: _____ Grade: _____ Teacher: _____

_____ No known drug allergies _____ Allergies (please list) _____

Over-The-Counter Medication Authorization

Medication Name: _____ Dosage: _____ Route: _____

Frequency/Time(s) to be given: _____ Start Date: _____ Stop Date: _____

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions _____

Treatment order in the event of adverse reaction: _____

PARENT AUTHORIZATION

I authorize the school Nurse, the registered nurse (RN) or licensed practical nurse (LPN), to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

Prescription Medication must be registered with the School Nurse or Trained Medication Assistant. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be presented to the School Nurse or Trained Medication Assistant. OTCs must be in the original, unopened, and sealed container. **OTC medication may not be kept for more than 2 weeks without written authorization from an authorized licensed healthcare provider.** Local Education Agency Policy for OTC medication must be followed.

Parent's/Guardian's Signature: _____ Date: _____ Phone: _____



JASPER CITY SCHOOLS ANNUAL NOTIFICATION REGARDING SCHOOL PROVIDED OR SPONSORED MENTAL HEALTH SERVICES

Mental Health Services

The school system provides or sponsors the following mental health services¹:

1. **Assessments or Surveys** - includes questionnaires provided to students related to social behaviors, feelings, etc.
2. **Crisis intervention** - short-term, immediate assistance by school counselor or professional for a specific situation.
3. **School-Based Mental Health** - On-going counseling services by school professionals or private practitioners in the school setting. Parent or legal guardian's permission will be obtained during an intake meeting before services are provided.

Review of Materials

You may request to review any materials used in the guidance and counseling programs available to students by contacting the student's principal.

Information Regarding How to Allow, Limit, or Prevent Your Child's Participation in Mental Health Services

Under Alabama law, no student under the age of fourteen may participate in ongoing school counseling services including, but not limited to, mental health services, unless (1) the student's parent or legal guardian has submitted a written opt-in granting permission for the student to participate or (2) there is an imminent threat to the health of the student or others.

Therefore, if your child is under fourteen, they will only be allowed to participate in mental health services if you opt-in. **If you would like the school system to be able to offer and/or provide mental health services to your child, you must opt-in for each service listed for them to participate in that service.**

Even if you do not opt-in to mental health services, your child may be provided mental health services if there is an imminent threat to their health or others. School employees may determine in their discretion whether such an imminent threat exists and provide any mental health services they deem necessary under the circumstances.

Parent of students with disabilities: Please note that the opt-in process is not applicable to any school counseling services or "mental health services" contained in a student's IEP or §504 plan. Consent for those services will be obtained and information regarding your child's mental health services will be provided through the usual special education process.

¹For purposes of this notification and policy, "mental health services" includes services, treatment, surveys, or assessments relating to mental health; however, it does not include instructional activities designed to educate students regarding topics related to mental health (1) contained in the school system's approved curriculum or (2) otherwise required to be taught by law (e.g., Erin's Law; Jamari Terrell Williams Student Bullying Prevention Act). "Ongoing school counseling services" for purposes of a required Opt-In shall not include those school counseling services which are split into domains not requiring a mental health therapist or other mental health therapeutic license.



JASPER CITY SCHOOLS OPT-IN FOR MENTAL HEALTH SERVICES

As of the date of my signature below, my child, _____, is under the age of 14 years old:

Yes

No

If No, stop here.

If Yes, continue below.

I hereby give my permission for my child to participate in the following mental health services:

(Check the box for each mental health service you want to be available to your child)

- Assessments/ Surveys**- includes questionnaires provided to students related to social behaviors, feelings, etc.
- Crisis intervention** – short-term, immediate assistance by school counselor or professional for a specific situation
- School- Based Mental Health** – On-going counseling by school professionals or private practitioners in the school setting. Parent or legal guardian's permission will be obtained during an intake meeting before services are provided.

You may rescind permission for a student to participate in mental health services at any time by providing written notice to school counselor.

Parent/Guardian Name (Printed)

Parent/ Guardian Name (Signature)

Date: _____

2025-2026

PARENT-STUDENT AGREEMENT AND PERMISSION FORM

- I have read the Jasper City Schools' Parent-Student Handbook, and I am fully aware of the policies and procedures set forth by the Jasper City Board of Education.
- I agree to follow all rules and policies as listed in the Jasper City Schools' *Parent-Student Handbook*.
- I have read and will adhere to the Acceptable Use Policy (AUP) on pages 52-54.
- I am aware of the video and picture taking guidelines found on page 58. I understand that Jasper City Schools does not condone anyone other than a parent or guardian to take pictures and/or videos of anyone other than their child.

Please complete the following:

- I hereby give my permission for the Jasper City School System to publish photographs and/or videos of my son/daughter and/or his/her work within the Jasper City Schools' domain and social media websites. Individual students may be identified by full name unless permission to do so is denied by the parent or guardian.

If you **do not** give permission for the Jasper City School System to publish photographs of your son/daughter and/or his/her work, you must notify the school principal in writing within fifteen days of the student's first day of attendance each school year.

-
- I hereby give my permission for my child to access the Internet with the supervision of his/her teacher as needed.

If you **do not** give permission for your child to access the Internet with the supervision of his/her teacher, you must notify the school principal in writing within fifteen days of the student's first day of attendance each school year.

-
- I hereby give my permission for my child to ride the bus for school or extracurricular activities.

If you **do not** give permission for your child to ride the bus for school or extracurricular activities, you must notify the school principal in writing within fifteen days of the student's first day of attendance each school year.

-
- I hereby give my permission for my child to participate in the Vision/Hearing Screening.

If you do not give permission for your child to participate in the Vision/Hearing Screening, you must notify the school principal in writing within fifteen days of the student's first day of attendance each school year.

STUDENT'S NAME: (please print) _____

SIGNATURE OF STUDENT: _____

SIGNATURE OF PARENT: _____

DATE: _____

SCHOOL: _____

**Please complete this form, remove from the handbook, and return to the school office.
Keep the handbook for future reference.**

**STUDENT/PARENT 2025-2026
ELECTRONIC DEVICE USE AGREEMENT**

Student Name: _____
Last Name First Name Grade/School

Parent Name: _____
Last Name First Name

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

TERMS:

1. I agree to practice digital citizenship and responsible social networking.
2. I agree to comply at all times with the Jasper City Schools Acceptable Use Policy and Equipment Use Agreement incorporated herein by reference and made a part hereof for all purposes. Any failure to comply may terminate my rights of possession effective immediately and the school system may repossess the electronic device and accessories.
3. I agree that I will not deface the device or accessories in any way including the addition of decals, markings, etc.
4. I agree that I will not alter (i.e. "jailbreak") the electronic device, software configuration, or functionality installed by Jasper City Schools.
5. I will take good care of my electronic device.
6. I will never leave the electronic device unattended.
7. I will never loan my electronic device to other individuals.
8. I will know where my electronic device is at all times.
9. I will charge my electronic device battery at home prior to each school day.
10. I will keep food and beverages away from my electronic device since they may cause damage to the device.
11. I will not disassemble any part of my electronic device or attempt any repairs.
12. I will protect my electronic device by only carrying it while in the case provided.
13. I will use my electronic device in ways that are appropriate, educational, and meet the expectations of Jasper City Schools.
14. I will not deface the serial number on the back of my electronic device.
15. I understand that my electronic device is subject to inspection at any time without notice and remains the property of Jasper City Schools.
16. I will follow the policies outlined in the Parent-Student Handbook and Acceptable Use Policy while at school, as well as outside the school day.
17. I will file a police report in case of theft, vandalism, or fire.
18. I will be responsible for all damage or loss caused by neglect or abuse.
19. I will honor myself and others by communicating in a respectful manner in all electronic communication.
20. I agree to return the electronic device, case, and power cords to Jasper City Schools in good working condition.
- 21. Students may wish to carry their own personal electronic device. If this is the case, the students must be attached to the school network and using the school content filter.**

SIGNATURES:

Student Parent/Guardian Date

TITLE:

Legal title to the electronic device and all accessories is in the name of Jasper City Schools and shall at all times remain so. My right of possession and use is limited to and conditioned upon my full and complete compliance with this Agreement and the Acceptable Use Policy.

COST OF LOST/REPAIRS FOR ELECTRONIC DEVICE AND ACCESSORIES

Furthermore, the student will be responsible for any damage to the electronic device and must return the electronic device and accessories to the school in satisfactory condition. The student will be charged for any needed repairs, not to exceed the replacement cost of the electronic device.

ELECTRONIC DEVICE REPLACEMENT CHARGES:

- Lost or *stolen device: Replacement of device \$200.00
- Device Repairs/ Broken Screen/ Broken Headphone Jack/ Port \$ 40.00
- Lost Accessory replacements:
 - iPad cord, charger, or case \$20.00
 - Chromebook cord or case \$30.00

*An electronic device that is considered stolen must have a police report

Jasper City Schools

Personally Owned Computing/Network Device Acceptance of Responsibility and Device Use Agreement Permission Form

I, _____ (Name of parent or guardian), agree to let _____ (Name of student) bring their personally owned computing device for instructional use in _____ (Name of school). I understand that the student named above will be permitted to use their personally owned device, subject to the conditions of this document.

I understand that if I agree to allow my student to use their own device that Jasper City Schools (JCS), is not responsible for any device or data loss, theft, infection, damage or other associated costs of replacement or repair incurred during the school day or at home as a result of participation in this program. **I understand that JCS Staff will be unable to store, support, or troubleshoot student owned devices.** The student named above will take full responsibility for the device and will appropriately secure all devices when not in use.

JCS uses technological measures such as filtering to promote internet safety. Filtering limits students' ability to access harmful internet sites from any device connected to the JCS network, but only when this equipment is used in school on the JCS network. Access through cellular networks does not provide the same measures of filtering. Students should only use the JCS network (not private cellular service) for internet access while on JCS property.

I have verified my student is aware that all aspects of *Parent-Student Handbook* - Student Code and Discipline, Student Guidelines of Acceptable Use Policy, Internet Guidelines, Ownership of Resources and Expectations of Privacy, page 56 and 57 of the *Parent-Student Handbook*, and Board Policy 6.1 prevents cyber-bullying apply to the use and care of their personal device while on JCS property or while involved in any JCS sponsored event/activity. I am responsible for ensuring the device uses security applications to protect the devices from infection and prevent spreading infections from the devices.

I understand that the purpose of allowing my student to use their own device is to participate in teacher approved activities in support of the JCS curriculum. Use of these devices for unrelated activities beyond or outside the JCS educational program are prohibited.

Parent or Guardian's Signature _____ **Date** ___/___/___

Student Acceptance

I agree to adhere to the AUP guidelines presented in the *Parent-Student Handbook* for Jasper City Schools. I will utilize the device(s) for instructional purposes only while at any JCS school or on the JCS network.

Student Signature _____ **Student ID#** _____

Date ___/___/___

JASPER CITY SCHOOLS PARENT\STUDENT

HANDBOOK ACKNOWLEDGEMENT

2025-2026

Student: _____

School: _____ Grade: _____

All Parents\Guardians and students in the Jasper City School District must acknowledge by signing this form that they have access to, and responsibility for the following items:

- An acknowledgement to the contents of the Jasper City School District Parent\Student Handbook found online at <https://www.jasper.k12.al.us/quick-links/registration-forms> .
- An acknowledgment of all local school policies.
- An acknowledgement that parents\guardians may view their child's student information online. Information such as grades, schedule, and attendance may be viewed by obtaining a password from the local school.
- That parent\guardians are financially responsible for lost\damaged textbooks, library books, school equipment, and mobile devices.
- That permission is given to use the child's photograph, video image, and photographic likeness for school purposes including videotapes, yearbook, social media and advertisements. (You may send a letter to the school principal if you do not want your child photographed for school purposes).
- Complete, sign, and return the Handbook Form Packet containing: Health Assessment Forms, Medication Prescriber Authorization Forms, Parent/Student Agreement and Permission Form, Electronic Device Use Agreement.

Student Signature: _____

Parent\Guardian Signature: _____

Date: _____