

**JEFFERSON PARISH SCHOOLS
HEALTH INFORMATION FORM
2026-2027**

Student Name _____ **Date of Birth** _____ **Grade** _____

Parent/Legal Guardian Name _____ **Parent/Legal Guardian Phone** _____

Parent/Legal Guardian E-mail Address _____

Hospital of Choice _____ **Physician Name** _____ **Physician Phone** _____

Does your child ride a bus? ☐ YES ☐ NO; Bus Number _____ Does your child attend aftercare? ☐ YES ☐ NO

HEALTH HISTORY (Check all that apply)

☐ Anemia	☐ Eczema	☐ Respiratory Disease
☐ Anxiety	☐ Feeding tube	☐ Scoliosis
☐ Attention Deficit/Hyperactivity Disorder (ADHD)	☐ Gastrointestinal Disease	☐ Seizures
☐ Autism	☐ Hemophilia	☐ Severe Speech Problems
☐ Blind/Partially Sighted	☐ Hypertension	☐ Thyroid Disease
☐ Cancer	☐ Kidney Disease	☐ Tourette Syndrome
☐ Cardiovascular Disease	☐ Musculoskeletal Disease	☐ Urological Disease
☐ Cerebral Palsy	☐ Obesity	☐ Vision Problems
☐ Conduct Disorder (CD)	☐ Obsessive-Compulsive Disorder (OCD)	☐ Other _____
☐ Cystic Fibrosis	☐ Oppositional Defiant Disorder (ODD)	_____
☐ Deaf/Hard of Hearing	☐ Post-Traumatic Stress Disorder	_____
☐ Depression	☐ Pregnant	_____
☐ Diabetes		

Condition Details

Does your child require medication at school for any of the above listed conditions? ☐ YES ☐ NO (Physician orders REQUIRED)

Does your child require any special procedures at school? ☐ YES ☐ NO (Physician orders and Health Conference with Nurse (REQUIRED)

ASTHMA

Does your child have asthma? ☐ YES ☐ NO

Currently prescribed medications and treatments for asthma: _____

Does your child require medication at school to treat their asthma? ☐ YES ☐ NO ☐ N/A (Physician orders REQUIRED)

SEVERE ALLERGY (Check all that apply, describe trigger and symptoms)

TYPE OF ALLERGY	SPECIFIC TRIGGER (cause)	SYMPTOMS OF REACTION (i.e. hives, difficulty breathing, etc.)
☐ Food		
☐ Medications		
☐ Insect Sting/Bites		
☐ OTHER		

Currently prescribed Medications and treatments for Severe Allergies _____

Does your child require medication at school to treat their severe allergy? ☐ YES ☐ NO ☐ N/A (Physician orders REQUIRED)

SPECIAL DIET (Jefferson Parish Schools Meal Modification form completed by physician REQUIRED)

Does your child require a modified diet? ☐ YES ☐ NO ☐ N/A

Please describe the required modifications: _____

I hereby acknowledge that this information will be reviewed by the school nurse and listed on my child's JCampus Health Profile. I understand that this data may be used to develop a plan of care for my child. I also give permission for health information to be shared with other Jefferson Parish Schools employees as needed to ensure my child's safety at school.

Parent Signature _____ **Date** _____

Health Services Department
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