

Rains ISD

STUDENT HEALTH INFORMATION CARD

Dear Parent,

It is necessary that we receive the following information in the school clinic so that we may provide both emergency and routine health care for your child while they are at school or school related activities. Please notify the campus health provider of any changes throughout the year.

STUDENT NAME _____ **BIRTH DATE** _____ **GRADE** _____

Mother Name: _____ Primary Phone: _____ Secondary Phone: _____

Father Name: _____ Primary Phone: _____ Secondary Phone: _____

Alternate Emergency Contact: _____ Phone: _____

Siblings (names and grades) _____

DOCTOR NAME: _____ Phone: _____

DENTIST NAME: _____ Phone: _____

Hospital Preference _____ Does student have health insurance? YES NO

RISD has my permission to contact my child's physician or dentist should it become medically necessary: YES NO

MY CHILD IS ALLERGIC TO:

Medications: _____ Food: _____

Other: _____

*Carries an Epipen? YES NO

Description of Reaction _____ *Has an Epipen at home? YES NO

*students must have written physician and parental permission on file in the clinic in order to self carry and self administer emergency medications while at school.

PLEASE CHECK (✓) IF APPLICABLE:

___ Attention Deficit (Hyperactivity) Disorder

___ Asthma

___ Autism

___ Blood Disorder

___ Cerebral Palsy

___ Cystic Fibrosis

___ Diabetes

___ Down Syndrome

___ Eating Disorder

___ Epilepsy/Seizure Disorder

___ Gastrointestinal Disorder/G-tube

___ Heart Condition

___ Kidney Disorder

___ Migraine Headaches

___ Muscular/Orthopedic Disorder

Braces/Splints

___ Neurological Disorder

___ Psychiatric/Psychological Disorder

Syndrome _____

___ Skin Condition

___ Speech Disorder

___ Spina Bifida

___ STD _____

___ Traumatic Brain Injury

___ Vision/Hearing Disorder

___ Other _____

If yes, please explain: _____

MY CHILD USES THE FOLLOWING MEDICATIONS EITHER AT HOME OR AT SCHOOL:

Name _____ Frequency _____ Dose _____ Reason _____

Name _____ Frequency _____ Dose _____ Reason _____

Name _____ Frequency _____ Dose _____ Reason _____

Name _____ Frequency _____ Dose _____ Reason _____

Name _____ Frequency _____ Dose _____ Reason _____

Parent Signature _____ Date _____

(Please see back)

Should I keep my child home or send them to school?

In order to prevent the spread of communicable disease, students must not come to school if they:

- Have a **fever** of **100.0** degrees or higher within the past 24 hours
- Have been **vomiting** or had **diarrhea** within the past 24 hours
- Have symptoms that keep your child from participating in school, such as:
 - ✧ Very tired or lack of appetite
 - ✧ Cough that he or she cannot control, sneezing often
 - ✧ Headache, body aches, or earache
 - ✧ Sore Throat—a little sore throat is ok for school, but a bad sore throat could be **strep throat**, even if there is no fever. Other signs of strep throat in children are headache, upset stomach, or rash. Call your doctor if your child has these signs. A special test is required to diagnose strep throat, flu, etc.
- **Keep your child home if they are coughing or sneezing often because this spreads the sickness to others.**

24 Hour Rule:

FEVER: Keep your child home until their **FEVER HAS BEEN GONE WITHOUT (fever-reducing) MEDICINE FOR 24 HOURS.**

Fevers are a sign that your child is contagious; returning to school too soon may slow recovery and make others sick.

VOMITING OR DIARRHEA: Keep your child home for 24 hours after the LAST time they vomited or had diarrhea.

ANTIBIOTICS: keep your child home until 24 hours after the FIRST dose of antibiotic.

Children do their best learning when they look good and feel good.
Please help keep ours disease-free!

For more information, or if you have questions, Please contact the school nurse.

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