PINE BLUFF SCHOOL DISTRICT

PBSD Excellence All Day Every Day

Pine Bluff School District · Pine Bluff · Arkansas

STUDENT HEALTH INFORMATION

Student's Name: ______________________________
Last Name

____
First Name

____
Middle Name

Grade Entering: ___________

School to Attend: ______________________

Birthdate: ____________________________

Female: ______ **Male:** ______ **Race:** ______

Had student ever attended Pine Bluff/Dollarway School District: Yes: _______ No: ________
School Previously Attended:______________________ Last Grade Attended at Previous School: _________
Previous School Address:______________________State:__________Phone #:____________________
Parent or Guardian's Name:______________________Relationship:____________________
Student's Current Address:______________________State:__________Zip Code:____________________
Telephone Numbers: Home/Cell:______________________Work:____________________
Student lives with:______________________Relationship:____________________

Emergency Contacts:
Name: ______________________ Relationship: ______________ Phone#: ______________
Name: ______________________ Relationship: ______________ Phone#: ______________

MEDICAL HISTORY

Allergies: Please list/specify all allergies below:
Environmental/Seasonal:______________________Insect:____________________
Food:______________________Latex:____________________
Medication:______________________Other:____________________

Check all that apply and provide additional details as needed.
Health information must be updated annually or as changes in their health condition(s) or treatment occurs.

ADD: ______________ADHD:______________ODD:______________
Asthma:______________Bipolar:______________Depression:______________
Diabetes:______________Eye/Vision: ______________ Glasses: __________ Contacts: __________
Heart Disease:______________Hearing Disorder:______________Hearing Aids:______________
Hypertension:______________Migraine:______________Nose Bleeds:______________
Pregnancy:______________Skin Condition:______________Scoliosis:______________
Seizure Disorder:______________Sickle Cell Anemia:______________Ulcers:______________

Does student have any other health problems or disabilities? Yes:______________No:______________
If yes, please explain:______________________________
Does this student take medication on regular basis? Yes: ______________No:______________
If yes, please list medication(s), dose and times to be taken:______________________________
____

Please list brothers and sisters of the student's family/household in the Pine Bluff School District.

NAME	SCHOOL	GRADE
1)		
2)		
3)		

PARENT PERMISSION FOR ROUTINE SCREENING

I hereby grant permission for my child to receive the routine screenings offered by the Pine Bluff School District. The screenings may include dental, growth and development, hearing, vision, scoliosis, height and/or weight. I understand I must provide a written statement to the school nurse should I request to revoke my consent to any or all of the screenings.

PARENT SIGNATURE:______________________________**DATE:** ______________

PINE BLUFF SCHOOL DISTRICT
STUDENT HEALTH INFORMATION CONTINUED

EMERGENCY MEDICAL INFORMATION:

Student Name: Last:______________________________First:______________________________Middle:______________

School: ____Grade:_____________________________Birthdate:____________

Parent/Guardian Name: ____ Contact #: _________________________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

1. The transfer of my child via ambulance to the hospital for emergency medical treatment.
   If your child has a "Do Not Resuscitate" (DNR) order, it is your responsibility to notify the school nurse.

2. The administration of any treatment deemed necessary by the attending emergency personnel, i.e. EMS responders, ER physicians, etc. You may contact my child's primary care physician or dentist if necessary to obtain medical information.

   Primary Care Physician: Dr.________________________________Ph#:_______________________________

   Primary Dental Physician: Dr.________________________________Ph#:_______________________________

STUDENT INSURANCE INFORMATION:

Medicaid Number:____

or

Student Insurance Information:________________________________**Insurance #:**_____________________________

(Name of Insurance Company)

<u>PLEASE NOTE:</u> The vision and hearing screenings conducted on your child in the Pine Bluff School District may meet the requirements for Medicaid/Insurance Billing if the student qualifies for the coverage. The insurance will be billed annually at no additional cost to the parent/guardian.

ADDITIONAL INFORMATION:

In order to protect your child's health information are there any Court Orders, Custody Orders, and Restraining Orders, etc. pertaining to your child that we need to be aware of? Yes:________________________No:_________________

If yes, please provide general explanation and a **copy of the orders/directives must be furnished to the school**:________
____
____

I have read and acknowledge the above information to be correct.

PARENT/GUARDIAN SIGNATURE:____**Date:**______________