



# New Braunfels ISD Nurse Information Card

## Student Information:

Teacher/ Student ID: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ Male/Female Grade: \_\_\_\_\_

Medical/ Developmental Problems: \_\_\_\_\_

Asthma No/ Yes Seizures No/ Yes Chicken Pox No/ Yes Date \_\_\_\_\_ Glasses/Contacts No/ Yes Type \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

I understand in signing below that the district will take the necessary precautions regarding my child's safety. I will provide the school with information regarding specific foods to which my child is allergic, the nature of the potential allergic reaction and an allergy action plan.

## Tuberculosis Screening Questions:

1. Have you had recent contact with someone with infectious TB? No Yes Date \_\_\_\_\_
2. Have you moved within the last 5 years to the US from Mexico, Latin America Caribbean, Africa, Eastern Europe or Asia? Country \_\_\_\_\_ No Yes Date \_\_\_\_\_
3. Have you traveled (lived with resident populations from Mexico, Latin America, Caribbean, Africa, Eastern Europe or Asia) for more than 3 weeks? Country \_\_\_\_\_ How Long? \_\_\_\_\_ No Yes Date \_\_\_\_\_

I give appropriate health or administrative personnel authority to call the Doctor concerning medical needs of my child.

Doctor: \_\_\_\_\_ Dentist: \_\_\_\_\_ No Yes

Insurance: No/ Yes If yes, type \_\_\_\_\_ School Age Siblings: No/ Yes Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_  
Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

## Parent Information:

\_\_\_\_\_  
Parent/Guardian Phone (Home) Phone (Work) Phone (Cell)

\_\_\_\_\_  
Parent/Guardian Phone (Home) Phone (Work) Phone (Cell)

## Emergency Contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

NBISD does not assume any financial responsibility but does wish to provide emergency care. By signing this card, I am giving the appropriate school personnel authority to call EMS, to transport, or obtain medical care if I or the alternate adults cannot be reached. I hereby grant permission for emergency medical care to be given by the attending physician and/or school personnel. I also give permission for EMS to be called and/or for my child to be transported as necessary by school personnel. I will NOT hold the school district financially responsible for the emergency care and/or transportation of my child. In addition, I release the NBISD and employees from liability due to any adverse reaction or complications my child could have from taking medication I request be given. Notice: Any medication, prescription or over the counter to be administered during the school day, must be brought by parent/guardian to the school nurse office, labeled and in the original container. A signed permission form from the parent/guardian must be given to the school nurse

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date