

Student ID Number: _____

STUDENT HEALTH FORM 2020-2021

Student's Legal Name: _____ Age: _____
Last First Middle

Grade: _____ School: _____ Birth Date: _____ Gender: _____

**** NEW Students Enrolling in North Kansas City Schools ****
PLEASE ATTACH a copy of current immunizations from the Physician or Clinic.
Students will NOT BE PERMITTED TO ENROLL without proof of state required immunizations.

Medication:

Does your student take medications? No Yes Diagnosis/Reason _____

Medication	Dose	Time(s)
------------	------	---------

Health Information:

Physician's Name _____ Phone _____ Date of Last Visit _____

Dentist's Name _____ Phone _____ Date of Last Visit _____

Hospital Preference _____

Has your child had or does your child have any of the following illnesses or diseases?

Chicken Pox	<input type="checkbox"/> No <input type="checkbox"/> Yes	(Age) _____	Mononucleosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	(Age) _____
Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	Scarlet Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	Other Contagious Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

- | | |
|---|--|
| <ul style="list-style-type: none"> • Allergies (Please list and specify below) (foods, medications, environment, animals, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes • Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes • Attention Deficit/Hyperactive Disorder <input type="checkbox"/> No <input type="checkbox"/> Yes • Behavior Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Bladder Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Bowel Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Broken Bones <input type="checkbox"/> No <input type="checkbox"/> Yes • Dental Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes • Frequent Ear Infections <input type="checkbox"/> No <input type="checkbox"/> Yes • Head Injury/Concussion <input type="checkbox"/> No <input type="checkbox"/> Yes • Hearing Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Heart Problems/Murmur <input type="checkbox"/> No <input type="checkbox"/> Yes | <ul style="list-style-type: none"> • Hospitalizations (other than newborn) <input type="checkbox"/> No <input type="checkbox"/> Yes • Injuries/Accidents <input type="checkbox"/> No <input type="checkbox"/> Yes • Mental/Emotional Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Physical Limitations <input type="checkbox"/> No <input type="checkbox"/> Yes • Pneumonia <input type="checkbox"/> No <input type="checkbox"/> Yes • Rash/Birthmark/Scar <input type="checkbox"/> No <input type="checkbox"/> Yes • Seizure Disorder <input type="checkbox"/> No <input type="checkbox"/> Yes • Speech Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Surgery <input type="checkbox"/> No <input type="checkbox"/> Yes • Sutures/Stitches <input type="checkbox"/> No <input type="checkbox"/> Yes • Tubes in Ears <input type="checkbox"/> No <input type="checkbox"/> Yes • Vision Problems <input type="checkbox"/> No <input type="checkbox"/> Yes • Wears Glasses/Contact <input type="checkbox"/> No <input type="checkbox"/> Yes • Other _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
|---|--|

Please explain yes answers here:

Child History:

Did the child have any problems from birth to the first year of age?

No Yes

Please explain yes answers here:

Student Concerns:

Do you have any concerns about your student's:

Vision No Yes Hearing No Yes Attention Span No Yes Emotional Development No Yes
Speech No Yes Behavior No Yes Ability to Learn No Yes Physical Development No Yes

Please explain yes answers here:

Emergency Benadryl Authorization:

I give the school nurse permission to administer Benadryl under a standing prescription order by a NKCS D advising physician during an emergency medical situation if there is a suspected allergy situation.

No Yes

X _____ Date

SIGNATURE of Parent/Guardian/Other

Date

Emergency EpiPen Authorization:

I give the school nurse permission to administer an EpiPen under a standing prescription order by a NKCS D advising physician during an emergency medical situation if there is a suspected allergy situation.

No Yes

X _____ Date

SIGNATURE of Parent/Guardian/Other

Date

Verification:

In case of illness or injury of my student, I understand the school will attempt to contact parents or guardians first. Then they will contact other persons I have listed- who are authorized to receive information, make certain medical decisions and have my student released to their custody. If none is available, the school is authorized to make whatever arrangements are deemed necessary to maintain my student's health including, but not limited to, emergency medical treatment.

I am the legal Parent/Guardian of this student. No Yes _____ Initials

If you are not the legal Parent/Guardian of this student, state your relationship to this student. _____

I verify that the information provided on this form is accurate and current.

X _____ Date

SIGNATURE of Parent/Guardian/Other

PRINTED Name of Parent/Guardian/Other

Date