Student ID Number:

STUDENT HEALTH FORM 2022-2023

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

Grade:_____School:_____Birth Date:_____Gender: _____

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 _____

Health Insurance Coverage (commercial, self pay, MO Health, etc.) _____

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

- Allergies *(Please list and specify below)* (foods, medications, environment, animals, etc.) □ No □ Yes
- Asthma □ No □ Yes
- Attention Deficit/Hyperactive Disorder □ No □ Yes
- Behavior Problems □ No □ Yes
- Bladder Problems □ No □ Yes
- Bowel Problems □ No □ Yes
- Broken Bones □ No □ Yes
- Chicken Pox Disease Month/Year_____ □ No □ Yes
- Dental Problems □ No □ Yes
- Diabetes ___Insulin ___Diet Controlled □ No □ Yes
- Frequent Ear Infections □ No □ Yes
- Head Injury/Concussion Month/Year_____ □ No □ Yes
- Hearing Problems □ No □ Yes
- Heart Problems/Murmur □ No □ Yes
- Hospitalizations (other than newborn) □ No □ Yes
- Injuries/Accidents □ No □ Yes
- Mental/Emotional Concerns □ No □ Yes
- Physical Limitations □ No □ Yes
- Pneumonia □ No □ Yes
- Seizure Disorder □ No □ Yes
- Speech Problems □ No □ Yes
- Surgery/Stitches □ No □ Yes
- Tubes in Ears □ No □ Yes
- Vision Problems □ No □ Yes
- Wears Glasses/Contact □ No □ Yes
- Other concerns please explain below □ No □ Yes

Please explain yes answers here:

_____
_____
_____
_____
_____

** 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.

Do you have any concerns about your student's health:

_____
_____
_____
_____

Emergency Benadryl Authorization:

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

□ No □ Yes

X_____ _____
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 NKCSD advising physician during an emergency medical situation if there is a suspected allergy situation.

□ No □ Yes

X_____ _____
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_____ _____ _____
SIGNATURE of Parent/Guardian/Other PRINTED Name of Parent/Guardian/Other Date