Student ID Number:

STUDENT HEALTH FORM 2018-2019

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?

		(Age)			(Age)
Chicken Pox	□ No □ Yes	_____	Mononucleosis	□ No □ Yes	_____
Hepatitis	□ No □ Yes	_____	Scarlet Fever	□ No □ Yes	_____
Meningitis	□ No □ Yes	_____	Other Contagious Disease	□ No □ Yes	_____

- Allergies *(Please list and specify below)* □ 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
- Dental Problems □ No □ Yes
- Diabetes □ No □ Yes
- Frequent Ear Infections □ No □ Yes
- Head Injury/Concussion □ No □ Yes
- Hearing Problems □ No □ Yes
- Heart Problems/Murmur □ No □ Yes
- Hospitalizations (other than newborn) □ No □ Yes
- Injuries/Accidents □ No □ Yes
- Mental/Emotional Problems □ No □ Yes
- Physical Limitations □ No □ Yes
- Pneumonia □ No □ Yes
- Rash/Birthmark/Scar □ No □ Yes
- Seizure Disorder □ No □ Yes
- Speech Problems □ No □ Yes
- Surgery □ No □ Yes
- Sutures/Stitches □ No □ Yes
- Tubes in Ears □ No □ Yes
- Vision Problems □ No □ Yes
- Wears Glasses/Contact □ No □ Yes
- Other_____ □ No □ 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 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