

USD #309 NICKERSON-SOUTH HUTCHINSON
STUDENT HEALTH & EMERGENCY FORM

08-09
School Year

STUDENT NAME _____, _____, _____
Last First Middle Preferred Name (nickname)

Grade: _____ Gender: F / M Birthdate: ____/____/____ Siblings _____
(circle one)

Doctor Name: _____ Phone: _____ Dentist Name: _____ Phone: _____

Hospital Preference: (In Case of Emergency) _____

Is your child covered by any health insurance? Yes No Dental? Yes No Vision? Yes No

Does your student have an allergy to any foods, medications, insects, latex or other substances? Yes No

If Yes, please list in detail: _____

Please circle if allergy is **severe** **moderate** **mild** List symptoms: _____

What medication(s) or treatment is used to treat the allergy? _____

Has your child ever had a severe "anaphylactic" reaction requiring emergency care (list date)? _____

Please check all that apply to your student:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies-seasonal | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Dyslexia/Learning Disorder | <input type="checkbox"/> Muscular/Orthopedic Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Psychiatric Psychological Disorder |
| <input type="checkbox"/> Chicken Pox - Date: _____ | <input type="checkbox"/> Epilepsy/Seizure Disorder/Tourettes | <input type="checkbox"/> Serious Accident |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Other: _____ |

If yes to any of the above, describe:

If vision problem – describe. If child wears glasses/contacts, and list name of doctor. If hearing - special seating/aids)

If your student is on medication, please list medication, dosage, frequency (how often) and reason for medication:

Please note any concerns of which the school nurse needs to be aware: _____

Yes No I give the school nurse permission to contact my student's physician or dentist should it become medically necessary.

Yes No I give the school nurse permission to share health information with staff on a need to know basis.

Yes No I give the school nurse permission to share my child's immunization information with the Kansas Immunization Program and Kansas Web registry (KSWebIZ) for purposes of assessment and reporting to prevent disease.

Signature of Parent or Guardian: _____ **Date:** _____