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

09-10
School Year

STUDENT NAME ______________________, ____________________ __________________ ______________________
Last First Middle Preferred Name (nickname)

Grade: ________ Gender: F / M (Circle one) **Birth date:** ____/____/____ **Siblings** ____

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:

- ☐ Allergies-seasonal
- ☐ ADHD
- ☐ Asthma
- ☐ Chicken Pox - Date:_____________
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Digestive Disorder
- ☐ Down Syndrome
- ☐ Dyslexia/Learning Disorder
- ☐ Eating Disorder
- ☐ Epilepsy/Seizure Disorder/Tourettes
- ☐ Heart Condition
- ☐ Hearing Problems
- ☐ Kidney Disorder
- ☐ Migraine Headache
- ☐ Muscular/Orthopedic Disorder
- ☐ Psychiatric Psychological Disorder
- ☐ Serious Accident
- ☐ Surgery
- ☐ Vision Problems
- ☐ 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)
____
____

Is your child exempt from any immunization due to religious beliefs or medical conditions? If so, which?
____

Below is for Office Use Only:
Medical Exemption form signed by physician and returned annually? ☐ Yes ☐ No
Religious Exemption signed and returned? ☐ Yes ☐ No

If your child 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:**____________________