

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

11-12  
School Year

STUDENT NAME \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last First Middle Preferred Name (nickname)

Grade: \_\_\_\_\_ Gender: F / M Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 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)

**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 (include meds taken at home), 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. (Asthma, Diabetes, etc)

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:** \_\_\_\_\_