STUDENT HEALTH HISTORY

Name ____ Date of Birth ____________ Grade _____

Information on this form will enable school staff to provide the best possible care in relation to your child's physical health. This information will be kept in your child's confidential school health record.

Does your child currently have any of the following? *(check all that apply)*

___ Asthma **___ Diabetes** **___ Seizures** **___ Bleeding Disorder** **___ ADD/ADHD**
___ Inhaler at Home **___ Inhaler at School** *(please sign the Permission for Medication form)*
___ Other *(please specify)*

Does your child have any allergies to medication, food, insect stings, or other substances? *(please list the allergen, what kind of reaction occurs, and how the allergy is treated)*

Does your child have visual or hearing difficulties? *(please specify – glasses, contacts, hearing aids, etc.)*

Does your child take any medications regularly? *(please sign the Permission for Medication form only if medications need to be taken at school)*

Name of Medication	**Dose**	**Time Administered**

During the school year Hearing, Vision, and Dental screens will be conducted per Kansas requirements. If you have questions or concerns please contact the school nurse. If you choose to opt out of any screens, please indicate below:

I give permission to share the above information with my child's teachers, support staff *(including bus drivers)* as deemed necessary to ensure my child's safety and health. **___ Yes ___ No**

I give permission to school authorities present during any emergency or accident involving this student to obtain the services of a physician and/or to transport the student to the nearest hospital. I also give permission to the physician to treat the student unless parent/guardian is present and requests otherwise. **___ Yes ___ No**

I give permission for my child's immunization records to be released to the Kansas Web IZ Immunization Registry for the purpose of assessment and reporting. Permission allows the school nurse to share your child's immunization records with Brown, Jackson, Marshall, or Nemaha County Health Departments, and/or your child's personal physician.
___ Yes ___ No

I affirm that the information on this registration form is correct to the best of my knowledge.

Parent/Guardian Signature ______________________________________ Date _____________