STUDENTS

Teacher _____
Grade _____
SSN _____

Student Health Record and Consent Form

School Year
_____

Please PRINT all information.
Sign and date at the bottom of the page

_____
Last Name First Name Middle Name Date of Birth

_____
Street Address City State/Zip Male/Female Married/Single

_____
Mother/Legal Guardian Home # Work # Cell #

_____
Father/Legal Guardian Home # Work # Cell #

_____
Parent Email Address

Emergency Contact (Outside Of Home)

NAME_____**Relationship to Student**_____

Home # _____ Work # _____ Cell #_____

_____
Passport Insurance: ☐ Yes ☐ No If yes, Number Medical Insurance ☐ Yes ☐ No Name ID# Group#

_____
Doctor Name & Phone # Dentist Name & Phone #

HEALTH HISTORY

Allergies: None ☐ Drugs ☐ Bee Stings ☐ Foods ☐ Other ☐
Please list and describe reaction _____
Does your child have an EPIPEN: ☐ Yes ☐ NO Rescue inhaler for Asthma : ☐ Yes ☐ NO

Medical Condition(s): (**at present time**). You may give further explanation on the back of this form.

☐ Asthma ☐ Seizures ☐ Hearing Problems ☐ Emotional Illness ☐ Diabetes ☐ Bleeding Disorder
☐ Vision Problems ☐ Orthopedic Problems ☐ Heart Problems ☐ ADHD/ADD ☐ Ear/Throat Infections
Other Health Concerns _____
Please explain any checks above _____
_____

List all medication(s) taken on a daily basis: Name(s) of drug(s) _____

_____

Consent for School Health Services

I consent to care which may include screening(s), assessment(s), treatment(s), first aid, over-the- counter Medicine(s) and any other health service given to me/my child by staff of this school health site. The school health staff may evaluate, assess and provide first aid treatment, but no medical diagnosis will be made. I give permission for health information to be exchanged with my child's physician if determined necessary by the school health staff. If my child has Medicaid or KCHIP, I also authorize the school health staff to release this information so the Medicaid/KCHIP can be billed for services.

Signature _____ Date _____

STUDENTS

DATE	NOTES
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