PLEASE RETURN WITH ENROLLMENT FORMS

USD 365 HEALTH HISTORY FORM

STUDENT INFORMATION

Name of Student _____ Grade _____ Date of Birth _____ Age _____

Home Address _____ Phone _____ Gender _____

Last School Attended _____ Social Security # _____

Race *circle one* White American Indian or Alaska Native Hispanic/Lation or of Spanish origin

Black or Afrianc American Native Hawaiian or other Pacific Islander Asian

Mother/Guardian's Name _____ Day Phone _____

Father/Guardian's Name _____ Day Phone _____

Mother Cell Phone _____ Father Cell Phone _____

Physician _____ City _____ Phone _____

Dentist _____ City _____ Phone _____

Eye Doctor _____ City _____ Phone _____

EMERGENCY CONTACTS (in cases when a Parent/Guardian cannot be reached)

1 Name (relationship) _____ Day Phone _____

2 Name (relationship) _____ Day Phone _____

HEALTH CONDITIONS (check all that apply)

- ❑ ADD/ADHD
- ❑ Medication Allergies _____
- ❑ Food Allergies _____
- ❑ Arthritis / Connective Tissue
- ❑ Asthma / Reactive Airway
- ❑ Behavioral / Emotional / Psychological
- ❑ Blood Disorder
- ❑ Brain / CNS Disorder
- ❑ Cancer
- ❑ Cardiovascular (Heart condition)
- ❑ Cerebral Palsy
- ❑ Cystic Fibrosis
- ❑ Developmental Delay
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Endocrine Disease
- ❑ G.I. Disorder (Stomach / Intestinal)
- ❑ Genetic Disorder
- ❑ Hearing Impaired / Ear Concerns
- ❑ Migraine Headaches
- ❑ Musculoskeletal Disorder
- ❑ Prosthesis
- ❑ Seizure Disorder
- ❑ Skin Disease
- ❑ Spina Bifida
- ❑ Urinary / Kidney Disease
- ❑ Visually Impaired
- ❑ Wears glasses / contacts
- ❑ Other (please list) _____
- ❑ Surgical History _____

Please fully explain any answers checked above (include severity and symptoms of any allergies)_____

_____

Please list any medications the student takes on a regular basis and state reason for taking_____

_____

_____

Please list any other factors that the school nurse, counselor or your child's teacher(s) should know of which might affect the student's ability to learn_____

_____

In order to better serve the health needs of my child

*I hereby give permission for the information in my child's health records to be shared with other appropriate professionals including my child's physician and/or health department.

*I hereby give my consent for my child's immunization records to be released to the Kansas Immunization Registry for assessment and reporting.

*I hereby give my permission for USD 365 personnel to seek treatement for my child in case of medical emergency.

*I understand this authorization will expire when my child is no longer enrolled in a school in USD 365.

_____ _____

Date *Parent/Guardian Signature*