School: ____________________
Grade: ______
Riding Bus? Yes_____No______
Today's Date: ________________

2017-2018

Central Kitsap School District

CONFIDENTIAL HEALTH INFORMATION

This form must be completed each year

PLEASE COMPLETE FORM & RETURN AS SOON AS POSSIBLE

Name: ______________________________________ Birthdate: ______________ M / F: ____________
Last First MI

Parent Name: ____________________________Address: ____________________________ Phone: ____________

Parent Name: ____________________________Address: ____________________________ Phone: ____________

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. **If your student has a LIFE THREATENING condition, an Individual Health Plan created by the school nurse needs to be in place before they can start school.**
In order to provide a safe and healthy environment for your child, this information will be accessible to the follow people: School Nurse, your child's teacher(s), office manager, personnel responsible for health room coverage and emergency medical personnel.

A. MEDICAL HISTORY: Check the ones that apply to your child and describe under the Comments section.

______ ADD/ADHD
______ Seasonal/Environmental Allergies
______ Anxiety/ Panic attack
______ Asthma
______ Bowel problem
______ Cerebral Palsy
______ Diabetes
______ Severe Allergy
______ Severe Allergy w/ Epi-Pen

______ Migraine Headaches
______ Severe Hearing problem
______ Heart Condition
______ Kidney/urinary problems
______ Muscular Disorder
______ Neurological Concern
______ Orthopedic problem
______ Seizures
______ Severe Vision problem

______ **Life Threatening Condition**
Explain: ________________________

______ **Diagnosed Emotional Concerns**
Explain: ________________________

______ **Other:** ____________________
Explain________________________

Comments: ____

B. ALLERGIES: List allergies your child has that may cause a problem at school:

Cause of the allergy: ____________________________ Treatment: ______________________________

Cause of the allergy: ____________________________ Treatment: ______________________________

C. MEDICATION: Include prescription and over-the-counter medication:

	Name	Used to treat	Taken at school?	
1)	______________________	______________________	Yes ☐	No ☐
2)	______________________	______________________	Yes ☐	No ☐
3)	______________________	______________________	Yes ☐	No ☐

Before medication of any kind can be administered at school, an Authorization to Administer Medication form, available in the office, must be completed by parent and physician and kept on file.

D. Name of Physician: ____________________________ **Phone:** ________________

Rev. 1/17