USD #368 HEALTH ASSESSMENT FORM

Student Name _____Grade _____ Gender_____ Date of Birth_____

****Does your child have any health condition that we should be aware of?** ☐Yes ☐No

Health Conditions: (check all that apply)

☐ADD/ADHD	☐Allergies (give details below)	☐Asthma
☐Behavior Concerns	☐Bladder/Kidney Concerns	☐Bone/Joint Problem
☐Cancer	☐Concussion History	☐Diabetes ☐Type 1☐Type 2
☐Emotional Concerns	☐Headache/Migraines	☐Hearing Loss/Aids
☐Heart Defects	☐Past Surgery	☐Seizure History
☐Stomach Issues	☐Visually Impaired	☐Other Diagnosis Not Listed

Allergies—Food, Environmental, Medication, Sting, Seasonal (Please give allergy and treatment detail):

_____

_____

Additional Information—Please provide for any conditions checked above:

_____

_____

_____

Current Medications: ☐None

☐Taken at Home_____

☐Taken As Needed_____

☐Will need to take at School (**Authorization for Medication form required**) _____

Health Office Medications

In accordance with label instructions, my child may receive all of the following over the counter medications available in the office, unless otherwise noted below: Cough drops, Caladryl Clear, Hydrocortisone cream, Antibiotic ointment, Vaseline, A&D ointment, Blistex, Refresh Eye Drops, Sting Free (for bug bites).

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USD #368 does NOT provide Tylenol or Ibuprofen for students. If you feel your child may need these medications during school a parent/guardian must provide the medication to the school office along with a completed medication form. All medication must be kept in the office.

In order to better serve the health needs of my child, I hereby recognize that information in my child's health records may be disclosed to appropriate USD #368 personnel including food service and health related professionals. I authorize school personnel to obtain emergency medical care, at my expense, for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained. I give consent for my child's immunization information to be obtained from or released to Kansas Immunization registry for the purposes of assessment and reporting.

Signature Parent/Guardian: _____Date: _____

Printed Name Parent/Guardian_____ Phone: _____