

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Allergies (give details below) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Behavior Concerns | <input type="checkbox"/> Bladder/Kidney Concerns | <input type="checkbox"/> Bone/Joint Problem |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Concussion History | <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 |
| <input type="checkbox"/> Emotional Concerns | <input type="checkbox"/> Headache/Migraines | <input type="checkbox"/> Hearing Loss/Aids |
| <input type="checkbox"/> Heart Defects | <input type="checkbox"/> Past Surgery | <input type="checkbox"/> Seizure History |
| <input type="checkbox"/> Stomach Issues | <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> 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).

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:** _____