Kenai Peninsula Borough School District

Health History

STUDENT NAME (print)_____**DOB**_____**GRADE**_____

SCHOOL_____

PERMISSION FOR EMERGENCY CARE ___YES ___NO

ALLERGIES ___NO____YES

Please list allergy, and describe the reaction and treatment:

_____

_____

CURRENT MEDICATIONS:_____

CURRENT MEDICAL ISSUES AND OTHER CONCERNS:

___ASTHMA

___DIABETES

___SEIZURES

___HISTORY OF HEAD INJURY

___VISION CONCERNS

___ HEARING CONCERNS

___SPEECH CONCERNS

___MENTAL/EMOTIONAL CONCERNS

OTHER ISSUES OR CONCERNS/ADDITIONALCOMMENTS_____

_____

CURRENT SPECIFIC MEDICAL DIAGNOSIS: No Yes

Diagnosis: _____ Date identified:_____

CARE/TREATMENT at school:_____

PAST MEDICAL INFORMATION: operations, injuries, hospitalizations, or past medical concerns:_____

_____

My signature allows for information that pertains to school safety or helps my child in the classroom, to be shared with additional school staff as appropriate.

PARENT/GUARDIAN COMPLETING THIS FORM:

NAME(print)_____RELATION_____

SIGNATURE_____DATE_____