

2011-2012

School: _____

Central Kitsap School District

Grade: _____

CONFIDENTIAL HEALTH INFORMATION

This form must be completed each year

PLEASE COMPLETE FORM & RETURN AS SOON AS POSSIBLE

Name: _____ Birthdate: _____ Today's Date: _____
Last First MI

Parent Name: _____ Address: _____ Phone: _____

Parent Name: _____ 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. It is very important to know of **LIFE THREATENING** conditions.

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 | _____ Severe Hearing problem | _____ Life Threatening Condition |
| _____ Anxiety/ Panic attack | _____ Heart Condition | Explain: _____ |
| _____ Asthma | _____ Kidney/urinary problems | |
| _____ Bowel problem | _____ Muscular Disorder | _____ Diagnosed Emotional Concerns |
| _____ Cerebral Palsy | _____ Neurological Concern | Explain: _____ |
| _____ Diabetes | _____ Orthopedic problem | |
| _____ Severe Allergy/Epi-Pen | _____ Seizures | _____ Other: _____ |
| _____ Migraine Headaches | _____ Severe Vision problem | Explain _____ |

Comments: _____

B. ALLERGIES: List allergies your child has that 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 <input type="checkbox"/>	No <input type="checkbox"/>
2) _____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3) _____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Before medication of any kind can be administered at school, a Physician's Order for Medication form , available in the office, must be completed by parent and physician and kept on file.

D. Name of Physician: _____ **Phone:** _____