

2018-2019
 Central Kitsap School District
CONFIDENTIAL HEALTH INFORMATION

School: _____
 Grade: _____
 Riding Bus? Yes _____ No _____
 Today's Date: _____

This form must be completed each year
PLEASE COMPLETE FORM & RETURN AS SOON AS POSSIBLE

Name: _____ Birthdate: _____ M / F: _____
 Last First MI

Parent Name: _____ Parent Name: _____
 Street Address: _____ Street Address: _____
 City: _____ Zip: _____ City: _____ Zip: _____
 Phone: _____ 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 Other Information.

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> *Severe Allergy
<input type="checkbox"/> *Severe Allergy w/ Epi-Pen
<input type="checkbox"/> Seasonal/Environmental Allergies
<input type="checkbox"/> Anxiety/ Panic attack
<input type="checkbox"/> Asthma
<input type="checkbox"/> Autism
<input type="checkbox"/> Bowel problem
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Downs Syndrome
<input type="checkbox"/> Diagnosed Emotional Concerns
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Severe Hearing problem
<input type="checkbox"/> Kidney/urinary problems
<input type="checkbox"/> Muscular Disorder
<input type="checkbox"/> Neurological Concern | <input type="checkbox"/> Orthopedic problem
<input type="checkbox"/> Seizures
<input type="checkbox"/> Severe Vision problem

<u>Other Information:</u>

_____ |
|--|--|---|
- *Describe Severe Allergy:

B. Other 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 <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, 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:** _____