School: ____________________
Grade: ______
Riding Bus? Yes_____No______
Today's Date: ________________

2019-2020

Central Kitsap School District

CONFIDENTIAL HEALTH INFORMATION

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.

______ ADD/ADHD
______ ***Severe Allergy**
______ ***Severe Allergy w/ Epi-Pen**
______ Seasonal/Environmental Allergies
______ Anxiety/ Panic attack
______ Asthma
______ Autism
______ Bowel problem
______ Cerebral Palsy
______ Developmental Delay

______ Diabetes
______ Downs Syndrome
______ Diagnosed Emotional Concerns
______ Migraine Headaches
______ Headaches
______ Heart Condition
______ Severe Hearing problem
______ Kidney/urinary problems
______ Muscular Disorder
______ Neurological Concern

______ Orthopedic problem
______ Seizures
______ Severe Vision problem

Other Information:
____
____
____
____
____
____
____
____
____

***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 ☐ No ☐
2)	____________________	____________________	Yes ☐ No ☐
3)	____________________	____________________	Yes ☐ No ☐

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:** ________________

Rev. 1/19

OFFICE: RETURN COMPLETED FORM TO NURSE