CKSD HEALTH INFORMATION FORM

Submit a new form each school year.

Student: _____ Birthdate: _____

School Year: _____ Grade: _____ School: _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Address: _____ Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

Phone: _____ Phone: _____

❑ **Check box if your child has a life-threatening condition**. An Individual Health Plan and any medication or treatment orders must be in place before starting school. Call your school nurse as soon as possible.

HISTORY: Check all conditions that apply. Use "Other/Explain" to provide additional information. Notify your school nurse of changes that occur throughout the school year. To provide a safe and healthy environment for your child, this information will be accessible to staff who may be called upon to assist with care.

❑ ADD/ADHD
❑ Allergic Reaction*
❑ Allergies – Seasonal/Environ*
❑ Anaphylactic Condition*
❑ Anxiety/Panic Attack
❑ Asthma/Respiratory Condition
❑ Autism
❑ Blood Condition
❑ Cancer
❑ Cerebral Palsy
❑ Congenital Condition
❑ Developmental Condition
❑ Diabetes ❑ Type 1 ❑ Type 2
❑ Gastrointestinal Condition
❑ Hearing Condition
❑ Heart Condition
❑ Immune Condition
❑ Joint Instability
❑ Kidney/Urinary Condition
❑ Mental/Behavioral Health
❑ Migraine/Headaches
❑ Neurological Condition
❑ Orthopedic Condition
❑ Seizure Condition
❑ Skin Condition
❑ Traumatic Brain Injury (TBI)
❑ Vision Condition

Other/Explain: _____

***ALLERGY:** does your child have an epinephrine auto-injector (EpiPen)? ❑ Yes ❑ No

Allergic to: _____ Describe reaction: _____

Treatment: _____

❑ **My child requires medication at school.** A medication authorization form must be submitted to the school. Forms and additional information are available through your school office or at ckschools.org.

Medication name: _____

❑ **My child requires a medical treatment at school (blood sugar check, tube feed, oxygen, etc).** For medical treatments to be performed at school, a treatment authorization is required. Forms and additional information are available through your school nurse or at ckschools.org
❑ **My child has a compromised immune system.**
❑ **My child requires an assistive device to move around.**
❑ **My child has food or fluid restrictions.** Explain: _____

Section 504: Many health conditions qualify as a disability under Section 504 of the Rehabilitation Act of 1973. Visit ckschools.org for information on Section 504 rights and protections.

_____ _____

Printed Name of Parent/Guardian Completing Form Today's Date

OFFICE – PROVIDE COPY TO NURSE