

Kenai Peninsula Borough School District

Health History

STUDENT NAME (print) _____ DOB _____ GRADE _____

SCHOOL _____

PERMISSION FOR EMERGENCY CARE YES NO

ALLERGIES YES NO

Please list allergy, and describe the reaction and treatment:

CURRENT MEDICATIONS: _____

CURRENT MEDICAL ISSUES AND OTHER CONCERNS:

ASTHMA

VISION CONCERNS

DIABETES

HEARING CONCERNS

SEIZURES

SPEECH CONCERNS

HISTORY OF HEAD INJURY

MENTAL/EMOTIONAL CONCERNS

OTHER ISSUES OR CONCERNS/ADDITIONAL COMMENTS _____

CURRENT SPECIFIC MEDICAL DIAGNOSIS: YES NO

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 _____