# USD 382 2008-2009 Student Health History

## Student Name _____ DOB _____

Please check any of the following that apply for your student and explain:

_____ Headaches _____ Sore Throat _____ Ear Infections/Earaches _____ Allergies
_____ Asthma _____ Heart Disease _____ Seizures _____ Diabetes _____ Digestive
_____ Oral/Dental _____ Urinary _____ Bowel _____ Back/Spine/Extremity Problems
_____ Coordination _____ Fractures _____ Surgeries _____ Speech _____ Skin Condition

Does your student have any special considerations, such as a disability, which may substantially limit the ability to perform a life activity? _____ yes _____ no If yes, please list such disability below:

Does your student have any allergies to foods, medication, environmental? ____ yes ____ no If yes, please list below:

List of medications administered regularly at home

List of medications that are/or need to be administered at school

In an **EMERGENCY** situation when we cannot reach you at home or at work, please list two people who have agreed to take responsibility for your child and consented to the release of their address and phone numbers so we may reach them as an alternative.

**Emergency Contact Person(s)**
Name and phone number of **first** contact: _____
Relationship to student _____
Name and phone number of **second** contact: _____
Relationship to student _____

**Medical Information**
Doctor's Name, location & phone # _____
Dentist's Name, location & phone #_____

If parent or guardian cannot be contacted, we, the undersigned parents of the child identified above, hereby authorize officials of the above school to contact directly the following physicians of our selection and we hereby certify that we are the parents of the said minor child, and do authorize the physicians named below to render such treatment as said physicians, or either of them, may deem reasonably necessary in an emergency, for the health of said child, without further authorization then here expressed. In the event neither of the physicians here named can be contacted, or either of us is unavailable to give our express consent at such time with reference to any other physi9cian we hereby consent and authorize the officials of the school to contact any licensed physician, and we hereby authorize said physician to render such treatment as he may deem reasonable and necessary, in what he may consider to be an emergency for the health of our aforesaid minor child.

_____
Parent/Guardian signature Date

Insurance Information
Insurance Company
_____
Policyholder name
_____
Insurance Number
_____
Policyholder Social Security #
_____

I give consent for information contained on the Kansas Certificate of Immunization to be released to the Kansas Immunization Program for the purpose of assessment and reporting of immunizations. I understand that this authorization will expire when the above-mentioned student is no longer enrolled in USD 382 and that I may revoke this authorization in writing at any time.

_____
Parent/Guardian signature Date

Field Trip Permission
I grant permission for my child to attend in-district functions Yes/No

For Grades 9-12 Only

No Child Left Behind of 2001 states that schools must comply with a request by a military recruiter or an institute of higher education for secondary students' names, addresses and phone numbers, unless the parent denies this request in writing. Non-compliance from the school will result in loss of federal funds.

I grant permission to release information to a military recruiter. Yes/No

I grant permission to release information to an institute of higher education Yes/No