Kaukauna Area School District

Health Information & Emergency Consent

Name ___________________________________ **Birth date** ___________**Grade**_______

Statement of your child's health in your own words: ________________________________
____
____

Medical Conditions: Check any of the following your child has had or now has.

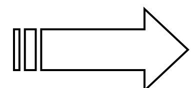
	YES	NO	WHEN		YES	NO	WHEN
ADD / ADHD *				Joint problems / Arthritis			
Asthma				Kidney trouble			
Cancer				Mental health *			
Concussion				Migraines			
Diabetes				Frequent Nosebleeds			
Frequent Headaches				Seizures with fever			
Heart trouble				Seizures without fever			
Hepatitis				Skin conditions			
High blood pressure				Tuberculosis			
Frequent Indigestion				Chicken Pox			
Wears Hearing Aides				Wears Glasses			

Parents of elementary students who have a diagnosis in any of the areas starred above will receive information from the classroom teacher on their child's behaviors related to that diagnosis a few weeks after the school year starts and as needed throughout the year. Secondary students will receive this information upon request to the school nurse. If you are not interested in receiving this type of information for your child, please notify the nurse at your child's school.

List any conditions, illnesses, surgeries, or injuries not mentioned above: ___________________
____
____
____

Medication: List any medication that your child is taking.

Medication Name	Amount	When to Use	Reason for Use
________________	________________	____________________	________________
________________	________________	____________________	________________
________________	________________	____________________	________________
________________	________________	____________________	________________



Name ___________________________________ **Birth date** ___________**Grade**_______

Allergies: Is your child allergic to any of the following? (Circle appropriate response)

Animals	YES / NO	Food	YES / NO	Medication	YES / NO
Bee Stings	YES / NO	Latex	YES / NO	Seasonal	YES / NO

If your child has allergies, is an Epi-pen required? YES / NO
If your child does require an Epi-pen will you provide one for school use? YES / No

List specific allergies and explain what symptoms your child may experience as a result of these allergies:____
____
____

Over-the-Counter Medication Administration Consent

I give my permission for the school nurse, or health assistant under the delegation of the school nurse, to administer the following selected over-the-counter medications in the dose strength indicated on the medication label for my minor child for the duration of the school year.

Acetaminophen (Tylenol)	yes / no	Ibuprofen	yes / no
Antacid (Tums)	yes / no	Antihistamine (Benadryl)	yes / no
Cough/cold	yes / no		

Additional parent instruction ____
____

- As needed prescription and over the counter medication will not routinely be sent on all field trips.
- It is the parent/guardian's responsibility to provide emergency medications for traveling to and from school and for school sponsored events.

Release of health information and emergency treatment

I give my permission for the preceding health and emergency information to be shared with appropriate school personnel as needed. Furthermore, in the event of an emergency or illness, when I cannot be reached, I authorize school personnel to notify and release pertinent health information to my child's designated emergency contact person(s), physician, and or emergency medical services staff. I also authorize treatment, administration of anesthesia, and surgical intervention for my minor child in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me.

Signature of Parent / Legal Guardian ______________________________ Date ____________

January 2017