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 illness			
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			

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OVER →

Name _____ Birth date _____Grade_____

Physician_____ Phone _____

Hospital preference _____

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 yes, parent/guardian is responsible for providing an Epi-Pen for school use

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 (Motrin)	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.

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 _____