

# Emergency/Health Form - Kenosha Unified School District No. 1

YR:	ID#
BUS#	

Student Last Name	First Name	Middle Name	Birthdate	School	Grade	Parent's eMail Address	Cell Phone
			( ) -				( ) -

Student Address (check if new) <input type="checkbox"/>	City	State	Zip Code	Home Phone (check if unlisted) <input type="checkbox"/>	Family doctor's Name	Doctor's Phone	Child's Dentist	Dentist's Phone
				( ) -			( ) -	

Parent/Guardian Name	Address	City	Home Phone	Child Lives with Y/N	Employed By	Work Phone and shift hours
			( ) -			( ) -

Parent/Guardian Name	Address	City	Home Phone	Child Lives with Y/N	Employed By	Work Phone and shift hours

**Please list additional emergency contacts below in the order you wish them to be called:**

Name	Address	Home Phone	Work Phone and Extension	Relationship to Student

Name	Address	Home Phone	Work Phone and Extension	Relationship to Student

**Confidential Health Information** If your child's doctor has told you your child has any of the problems noted below, please "X" all that apply and answer questions related to problem.

- My child has no known health problems     **MY CHILD'S HEALTH CONDITION IS POTENTIALLY LIFE THREATENING**
- Attention Deficit Disorder** with or without hyperactivity     Does your child have a form of Autism? If yes, describe \_\_\_\_\_
- Allergies, Types:**     Foods, list foods: \_\_\_\_\_
- Bees/Wasps/Other Insects     Latex/Rubber     Allergies to Medications: (List here) \_\_\_\_\_
- Other, please describe \_\_\_\_\_
- Asthma** or other breathing problems, describe: \_\_\_\_\_
- Conditions or problems that affect walking or movement**, describe: \_\_\_\_\_
- Cancer**, Type: \_\_\_\_\_    Currently in:     Treatment     Remission
- Birth Defects**, list/explain: \_\_\_\_\_
- Blood Disorder** other than HIV/AIDS (i.e. Sickle Cell), describe: \_\_\_\_\_     **Elevated Lead Level**
- Diabetes. (Circle:) Type I or Type II** List types of insulin, dose and times taken on back.
- Emotional/Psychological problems**, describe: \_\_\_\_\_
- Heart Condition**, describe: \_\_\_\_\_
- Organ Transplant**, list organ: \_\_\_\_\_
- Seizure Disorder**, describe type: \_\_\_\_\_    Date of last seizure: \_\_\_\_\_
- Swallowing, Stomach or Intestinal disorders:** \_\_\_\_\_
- Vision, Hearing or Speech** problems, describe: \_\_\_\_\_     Hearing Aids     Ear Tubes     Glasses
- Other**, describe: \_\_\_\_\_

**\*\*\*LIST ALL MEDICATIONS AND/OR TREATMENTS ON THE BACK OF THIS FORM\*\*\***

If my child becomes ill at school and you cannot reach me by phone, the principal or his/her designee has permission to contact any of the emergency contacts listed above. You have our permission to contact the Student's Physician for consultation if needed. If a serious illness or accident occurs at school, I understand that my child will be sent by rescue squad to the emergency room. (All expenses charged by the hospital are the responsibility of the Parent/Guardian.)

**SIGNATURE of Parent/Legal Guardian:** \_\_\_\_\_    **Date:** \_\_\_\_\_    **Language Used:** \_\_\_\_\_

**STUDENT NAME:** \_\_\_\_\_

**MEDICATION (List names of all medications child takes, doses and times given):**

*Each medication given at school requires written parental consent. Each prescription medication requires a physician's written order and written parental consent. Medication forms may be obtained from the school office.*

<u>MEDICATION (name)</u>	<u>DOSE</u>	<u>TIME or SITUATION</u> (When Given)	<u>WHO ADMINISTERS</u> (Child/Adult)	<u>WHERE KEPT</u> (Home/School/Backpack...)
1 _____				
2 _____				
3 _____				
4 _____				
5 _____				
6 _____				
7 _____				