Emergency/Health Form – Kenosha Unified School District No. 1

YR: ID#

Student Last Name | First Name | Middle Name | Birth date | School | Grade | Parent's Email Address | Cell Phone | Bus#

Student Address (check if new) ☐ | City | State | Zip Code | Home Phone (check if unlisted) ☐ | Family Doctor's Name | Doctor's Phone | Child's Dentist | Dentist Phone

Parent/Guardian Name | Address | City | Home Phone | Cell Phone | Child Lives with Y/N | Employed by | Work Phone & shift hours

Parent/Guardian Name | Address | City | Home Phone | Cell Phone | Child Lives with Y/N | Employed by | Work Phone & shift hours

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

Name | Address | Home Phone | Cell Phone | Work Phone and Ext | Relationship to Student

Name | Address | Home Phone | Cell Phone | Work Phone and Ext | 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 1** or **Type 2** List types of insulin, dose and times taken on back.

☐ **Emotional/Psychological problems**, describe: _____

☐ **Heart Condition**, describe: _____

☐ **Nerve Disorders** other than seizure/epilepsy, describe: _____

☐ **Organ Transplant**, list organ: _____

☐ **Seizure Disorder**, describe type: _____

☐ **Swallowing, Stomach or Intestinal** disorders: _____

☐ **Vision, Hearing, or Speech** problems, describe: _____ ☐ Hearing Aids ☐ Ear Tubes ☐ Glasses

☐ **Other**, describe: _____

***** PLEASE 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 spoken at home?** _____

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CONTINUED ON BACK

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.

MEDICATION (name)	DOSE	TIME OR SITUATION (when given)	WHO ADMINISTERS (child/adult)	WHERE KEPT (Home / School / Backpack…)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				