USD 315 Colby Public Schools Health History Form

Student's Name: _____ Male/Female Birthdate:_____ Grade:_____

Name of Parents/Guardians: _____

Address: _____ Phone: _____

Name of Primary Care Physician:_____ Date of Last Exam: _____

Name of Dental Provider: _____ Date of Last Exam: _____

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child had any problem with the following? If yes, please make a comment.

	YES	COMMENTS
Allergies (Please List)		*Food Allergy Requires Action Plan signed by Physician*
Asthma		*Requires Asthma Action Plan signed by Physician*
Seizures		*Requires Seizure Action Plan signed by Physician*
Diabetes		*Requires Diabetic Medical Management Plan signed by Physician*
ADD/ADHD		
Emotional Behavior Disorder		
Birth Defects		
Frequent Ear Infections		
Tubes in Ears (Date of Surgery)		
Heart Problems		
Vision/Hearing Problems		
Braces or Oral Appliances		
Skin Disorder		
Headaches		
Limits of Physical Activity		
Bladder and/or Bowel Problems		
Hospitalizations/Surgeries		
Frequent Nose Bleeds		
Other		

Does your child take any medications? **YES** **NO** If yes, please list names of medications:_____

_____

_____

_____

Will any of these medications be given at school? **YES** **NO** If yes, a physician's order is required.

*** * PLEASE COMPLETE THE INFORMATION ON BOTH SIDES OF THIS SHEET. * ***

Will your child require any special treatment or medical related procedure while at school? **YES** **NO**

If yes, please explain: _____

_____

Screening Information:

Screenings will be held in the fall of every school year. Not all grades are required to be screened every year, but students may be screened per parent or teacher request anytime during the school year. Please note these are screenings only, and do not replace professional evaluations. Screenings will be completed on the following grades:

Height & Weights (K-6th)
Hearing & Vision (K-3, 5th, 7th, 9th and 11th)
Oral Health (All)

If there are any concerns identified during the screening, parents/guardians will be notified either by phone or mail. Medical referrals will be the parents/guardians responsibility to have student further evaluated by a professional. Follow up will be completed by the school nurse and/or qualified NKESC staff.

If screening results are normal, parents/guardians will not be contacted.

If you wish to NOT have your child screened in one or more of the screening areas, please send a dated written request to the school nurse office.

Jennifer Eatherly, RN
USD 315 District Nurse
210 N. Grant
Colby, KS 67701

Immunizations:

There are times when the exchange of immunizations is necessary for medical records and immunization administration. I authorize USD 315 to release immunization information in his/her/their possession on the student named on the reverse side of this form to:

County Health Department
Health Provider/Physician
Kansas Immunization Registry/KsWebIZ

I affirm that I am authorized to consent to release of medical information on behalf of the student. I understand that this authorization will expire when the student is no longer enrolled in the above-named school and that I may revoke this authorization in writing at any time. By signing below I am stating understanding of the information provided. My signature will also serve as consent for immunization exchange and permission for screenings to be completed.

We understand this information will be reviewed by the school nurse and released to staff members only if deemed necessary. We hereby give our permission for school authorities to take care of our child as they may deem advisable should they not be able to contact us at the time of an accident or illness. IN CASES OF AN EMERGENCY, THE SCHOOL WILL CALL 911 BEFORE CALLING PARENTS/GUARDIANS.

_____ _____

Parent/Guardian Signature **Date**

If you have any questions or would like to discuss any health concerns, please call the school nurse at 460-5111 between 8:00 a.m. and 3:50 p.m. Monday – Friday.

*** * PLEASE COMPLETE THE INFORMATION ON BOTH SIDES OF THIS SHEET. * ***