

**MARY M. KNIGHT SCHOOL DISTRICT NO. 311
STUDENT HEALTH INFORMATION**

Last Name: _____ First Name: _____ Date of Birth: _____

Does your child take any medication while at home? Yes No
Does your child take any medication while at school? Yes No

List all medications: _____

Physician's Name: _____ Clinic Name: _____ Phone #: _____

Dentist's Name: _____ Clinic Name: _____ Phone #: _____

Please describe any health concerns regarding your child. It is important to keep school personnel informed of any changes in health conditions or medications that could affect your child's school performance.

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:	COMMENTS & DATES RELATED TO CONDITIONS. (DESCRIBE REACTIONS)
<input type="checkbox"/> ADD/ADHD (R20) Record of diagnosis is required to be on file.	
<input type="checkbox"/> Allergies, Other (A) <input type="checkbox"/> Bee Sting (A10) <input type="checkbox"/> Drug (A13) <input type="checkbox"/> Pollens (A12) <input type="checkbox"/> Food (A15)	Anaphylactic <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma/Respiratory (B10) <input type="checkbox"/> Exercised Induced (B11) <input type="checkbox"/> With Allergies (B12)	Inhaler Used <input type="checkbox"/> Yes <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Carries Own <input type="checkbox"/> No
<input type="checkbox"/> Chronic Earaches (EA1) <input type="checkbox"/> History of Ear Infections (EA)	
<input type="checkbox"/> Diabetes (D) <input type="checkbox"/> Insulin Dependent (D10) <input type="checkbox"/> Diet Controlled (D11) <input type="checkbox"/> Non-Insulin Dependent (D12)	
<input type="checkbox"/> Hearing Loss (H) <input type="checkbox"/> Mild (H10) <input type="checkbox"/> Severe (H12) <input type="checkbox"/> Moderate (H11) <input type="checkbox"/> Hearing Aid (H20)	
<input type="checkbox"/> Heart Problem (C9)	
<input type="checkbox"/> Language / Speech Delayed (SP)	
<input type="checkbox"/> Nosebleeds (NB)	
<input type="checkbox"/> Orthopedic Condition (OC) <input type="checkbox"/> Fractures (OC1) <input type="checkbox"/> Dislocations (OC3) <input type="checkbox"/> Sprains (OC2)	
<input type="checkbox"/> Other Illness (OI) <input type="checkbox"/> Hepatitis (OI1) <input type="checkbox"/> Kidney (K10) <input type="checkbox"/> Mononucleosis (OI4)	
<input type="checkbox"/> Physical Disability (PD)	
<input type="checkbox"/> Seizure Disorder (F)	
<input type="checkbox"/> Visual Problems (E) <input type="checkbox"/> Legally Blind (E10) <input type="checkbox"/> Color Blind (E26) <input type="checkbox"/> Visual Deficit (E12) <input type="checkbox"/> Wears Glasses	

Authorization to Administer Oral Medications Form must be signed by parent and physician and on file in the school office.

I hereby authorize and give my consent to the authorities of Mary M. Knight School District No. 311 to obtain emergency medical treatment. I also authorize medical authorities to perform upon or administer necessary medical or surgical treatment to the above named student. District authorities are not excused from attempting to contact me before relying upon this authorization. I understand that I will assume full responsibility for the payment of any services rendered.

I understand that the information listed above may be shared with school personnel on a need to know basis to facilitate the school district in providing a safe environment for my son / daughter.

Parent/Guardian Signature: _____ Date: _____