Mary M. Knight School District

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 Number: _____

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

Please describe any health concerns regarding your child. It is important to keep school personnel informed of any change 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)
☐ ADD/ADHD (R20)	Record of diagnosis is required to be on file.	
☐ Allergies, other (A)	☐ Bee Sting (A10) ☐ Drug (A13) ☐ Pollens (A12) ☐ Food (A15)	Anaphylactic ☐ Yes ☐ No
☐ Asthma/Respiratory	☐ Exercised Induced (B11) ☐ With Allergies (B12)	Inhaler Used ☐ Yes ☐ No ☐ Home ☐ School ☐ Carries Own
☐ Chronic Earaches (EA1)	☐ History of Ear Infections (EA)	
☐ Diabetes (D)	☐ Insulin Dependent (D10) ☐ Diet Controlled (D11) ☐ Non-Insulin Dependent (d12)	
☐ Hearing Loss (H)	☐ Mild (H10) ☐ Severe (H12) ☐ Moderate (H11) ☐ Hearing Aid (H20)	
☐ Heart Problem (C9)		
☐ Language/Speech Delay (SP)		
☐ Nosebleeds (NB)		
☐ Orthopedic Condition (OC)	☐ Fractures (OC1) ☐ Dislocations (OC3) ☐ Sprains (OC2)	
☐ Other Illness (OI)	☐Hepatitis (OI1) ☐ Kidney (K10) ☐ Mononucleosis (OI4)	
☐ Physical Disability (PD)		
☐ Seizure Disorder (F)		
☐ Visual Problems (E)	☐ Legally Blind (E10) ☐ Color Blind (E26) ☐ Visual Deficit (E12) ☐ 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: _____