Kalispell Public Schools

Student Health History Form

Student's Name_____

Birth date:____/____/____ Male____ Female_____

School:_____ Grade:_____

The following information is **Confidential**. Parents/guardians are required to complete **a new form each school year** or if new medical information updated.

PERMISSION TO GIVE NON-PRESCRIPTION MEDICATION AT SCHOOL

My child may receive medication(s) in my absence that I checked below from the school health clinic (dosed according to the medication label- only medications listed are provided in limited supply from school and are used sparingly)

- ☐ Acetaminophen - Tylenol
- ☐ Ibuprofen -Motrin
- ☐ Antacids (Tums/Mylanta)- Cough Drops -Oral Numbing Gel - Glucose Tabs
- ☐ Diphenhydramine (generic Benadryl)
- ☐ Topicals (includes Hydrogen Peroxide, Antibiotic ointment/ Hydrocortisone, Anti-itch cream, Vaseline, Carmex/Blistex, Hand/body lotion, Saline, Caladryl/Calamine lotion, Sting kill (Benzocaine), Sunburn relief lotion (may contain aloe and/or lidocaine)

Comments:_____

_____

DAILY MEDICATIONS

Does your child take daily medications? ☐Yes ☐No (If yes, please list the current medications)

Name of Medication	Dose	Time given	Reason given

Does your child require medication to be given at school? ☐No ☐Yes (if yes, please contact your school nurse)

- All prescription medication to be given at school require a medical order from your child's physician for school
- **Only parents/guardians are allowed to bring medication to school. Do not send with your student.** See your student handbook for rules/regulations regarding medication at school.

MEDICAL HISTORY

Does your child have any of the following conditions? (Check all that apply, explain in the box below) ☐ **None**

☐ ASD (Autism)	☐ Cancer	☐ Genetic/Congenital	☐Migraines
☐ ADD/ADHD	☐ Diabetes	☐ Glasses/Contacts	☐Other
☐ Asthma	☐ Eating Disorder	☐ Heart Condition	☐Sleep disorder
☐ Blood Disease	☐ Emotional Concerns	☐ Head injury/concussion	☐Seizures
☐ Bowel/Bladder	☐ Food Allergy/Intolerance	☐ Hearing Impaired	☐Stomach-frequent

Comments/Concerns

List any recent hospitalization or treatments and explain (please include dates):

_____

_____

Don't forget to complete the back side of this form

ALLERGIES

Does your child have any significant allergies? (Include known food allergies) ☐Yes ☐No

If yes, list allergy(s) and symptom(s) of allergic reaction:_____

_____

How is the allergy treated? _____

Does your child have EPI PEN, EPI JR or Auvi-Q prescribed to treat the allergy? ☐Yes ☐No

(If yes, please contact your school nurse before the first day of school to prepare an emergency action plan)

MEDICAL PROCEDURES OR TREATMENTS REQUEST

Does your child have any special medical procedures or emergency treatments needed during school hours? ☐Yes* ☐No

*All medical procedures or treatments required at school must have a doctor medical order on file with the school nurse before any nursing procedures/treatments can be performed. Orders are good for 1 school year; please contact your school nurse for assistance.

ACTIVITY RESTRICTIONS

Does your child have any restrictions for physical activities? ☐Yes ☐No

If yes, a written note from your physician for the current school year, stating the restrictions is required and needs to be updated yearly.

IMMUNIZATION REQUIREMENTS

Make sure your nurse has an up to date copy of child's vaccine record. Immunization records or religious objections or medical exemptions are due to the school nurse before the first day of school. Objections and exemptions must be resubmitted every school year. Any student who does not have the Montana State required school immunizations on file before the first day of school will be excluded until proof of vaccination is provided. Contact your physician or the school nurse if you have any questions.

* See the district website for required vaccines by grade level.

EMERGENCY CARE

This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. In case of an emergency, if the school is not able to contact me, I give permission to take the student to the nearest hospital or appropriate facility for medical attention. This medical information may be shared with school personnel, EMT's, and hospital personnel as needed. If it is necessary to contact an ambulance, it will be the responsibility of the parent/guardian to pay for this service. I understand a copy of this information will be sent with my child to the hospital. If I cannot be reached by telephone in the event of an emergency involving:

_____(student's name).

Please send my child to _____ or any available medical service.
(Hospital Preferred)

This information is current and correct; I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes in contact information. I understand that this health history form must be updated every school year.

_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Name Phone number

<u>Kindergarten students</u>- a physical exam is highly recommended before starting school. Please provide a copy of the exam and your child's immunization record to your school nurse along with this form.

TO BE COMPLETE BY KALISPELL PUBLIC SCHOOLS NURSING STAFF ONLY

☐Allergy/Anaphylaxis Emergency Action Plan ☐Asthma Action Plan ☐Diabetes Care Plan ☐ Seizure Action Plan

☐ Other treatments for school_____ ☐Health care plan needed