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

YR: | ID# | BUS#

Student Last Name | First Name | Middle Name | Birthdate | School | Grade | Parent's email Address

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's Phone ( ) -

Parent/Guardian Name | Address | City | Home Phone ( ) - | Child Lives with Y/N | Employed By | Work Phone and shift hours ( ) -

Parent/Guardian Name | Address | City | Home Phone ( ) - | Child Lives with Y/N | Employed By | Work Phone and shift hours ( ) -

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

Name | Address | Home Phone | Work Phone and Extension | Relationship to Student

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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 I or Type II** List types of insulin, dose and times taken on back.

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

☐ **Heart Condition,** describe: ______

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

☐ **Seizure Disorder,** describe type: ______ Date of last seizure: ______

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

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

☐ **Other,** describe: ______

*****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 Used:** ______

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.				

Your signature indicates permission to place your child's immunization history in a secured, computerized internet registry which will be shared with the public health department in accordance with the laws of the State of Wisconsin.

____

Parent Signature