

Kingsburg Elementary Charter School District 2020-2021
Student Health History/Emergency Information

Last Name _____ First _____ MI _____ Birthdate _____ M F Grade _____

Doctor _____ Phone # _____ Dentist _____ Phone# _____

Check only those that apply and return to school office

*SIGNATURE AND DATE REQUIRED ON BACK

ADD/ADHD: Requires medication? Yes No Name of medication _____
Given at school? Yes No Doctor name/phone _____

Asthma: Requires medication/inhaler? Yes No Daily? As needed? With exercise?
Name of medication _____ Given at school? Yes No

*Allergic reaction: To what? _____ Hive/rash? Yes No
(Severe) Breathing difficulty? Yes No has epi-pen? Yes No
Action required _____
Doctor name/number _____

Bladder/Kidney Yes No Explain: _____

Clinical Depression Requires medication? Yes No Name of medication _____
Given at school? Yes No Doctor name/number _____

Diabetes: Type I Type II Medications? Oral Injection given at school? Yes No Pump?
Name of medication _____ Doctor name/number _____

Ear Problems Frequent infection? Past Present Permanent hearing loss? Date of last exam _____

*Seizure Disorder Date of last seizure _____ Requires medication? Yes No
Name of medication _____ Doctor name/number _____

Heart Problems Diagnosis _____ Doctor name/number _____

Hospitalization Date/Explain _____
(Recent 12 months)

Orthopedic Corrective shoes/braces? Crutches Wheelchair? Physical therapy?
Conditions CCS? Other physical limitations _____

Vision Problems Wears glasses? All the time Reading only Contacts Date of last exam _____

Calif. Ed Code 49423-Students taking medication at school need an "Authorization for Medication" form completed annually.

This form must be on file with the school before medication can be given.

*These conditions require a Health Care Plan. Note: Any of the above conditions may require a Health Care Plan.

All forms can be obtained from the School Health Office.

Please complete back side and sign



Please list other important health or behavior information

California Education Code 49480 requires parent/legal guardians to inform the school nurse or designated, certified school employee of any child taking medication for a continuing time. With the consent of the parent/legal guardian the school nurse may communicate with the doctor and may counsel school staff regarding possible effects of the drug.

Is the child taking medication regularly? No _____ Yes _____ If yes complete the following:

Kind of Medicine	Dose	Physician	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CEC 49423. If prescribed medication is needed during the required school day, assistance may be given if the school receives: (1) a written statement from the physician detailing the method, amount and time schedule; and (2) a written statement from the parent/guardian, etc. **The medication must be clearly labeled and sent to the school in a container from the pharmacy (form available at school).**

Medical Insurance Carrier _____

Policy Number _____ Address _____

Father's/Guardian Driver's License No. _____

Mother's/Guardian's Driver's License No. _____

Sibling's (Oldest to Youngest)

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

NO KNOWN HEALTH PROBLEMS/SPECIAL NEEDS

Parent's/Guardian's
Signature _____ Date _____