Kinkaid EMSI Health Form **Summer 2024**

TO BE COMPLETED BY THE PARENT (Please add additional information on back of form)

Student's Last Name_____ First Name_____ FALL Grade Level _____

Address _____ Home Phone _____

Birthdate _____Male/Female (M/F) _____ Medical/Religious Exemptions? ☐ No ☐ Yes (If yes, attach affidavit/certificate)

Please note that The Kinkaid School does not have mental health support on campus during the summer. (initial)

If a student is having a mental health crisis on The Kinkaid School campus and the school nurse has concerns that the student could be at risk to self or others, 911 will be called and a parent will be notified. (initial)

Check all conditions that apply: ☐ Anaphylaxis ☐ Asthma ☐ ADHS/ADD ☐ Diabetes ☐ Heart Condition ☐ Seizures

List all Prescription & OTC Medications taken daily *at home*:

_____

Allergies: ☐ No ☐ Yes, List:

Check the generic over the counter (OTC) medications your child may have while on campus to be administered per product label:

☐ Tylenol ☐ Sudafed PE ☐ Guaifenesin ☐ Tums ☐ Advil ☐ Claritin ☐ Throat Lozenges ☐ Hydrocortisone 1% Cream

☐ Bacitracin Ointment ☐ Benadryl

Mother/Guardian 1's Full Name: _____

Email address: _____ Work Phone: _____ Cell: _____

Father/Guardian 2's Full Name: _____

Email address: _____ Work Phone: _____ Cell: _____

Person(s) to call if the guardians are not available:

Name: _____ Cell: _____

Name: _____ Cell: _____

Child's Doctor: _____ Phone: _____

☐Advil

☐Bacitracin Ointment

☐Guaifenesin

☐Hydrocortisone 1% Cream

PLEASE ATTACH CURRENT IMMUNIZATION RECORD

Health Information Release

I have read and agree the information on this form, with any initialed changes, is correct. I give permission for the information on this health form to be shared with school personnel on a need-to-know basis in order to provide appropriate services for my child. I agree to notify the school of any changes in my child's health status.

Emergency Treatment Release

In the event of an emergency, I give permission for treatment of my child by school personnel or a physician. The school will notify the parents as soon as possible.

Parent's Signature Date _

If a student is taking prescription medication *at school*, the information belo **MUST** be completed by a physician.

RX Med:_____ Dose:_____ Frequency:_____

RX Med:_____ Dose:_____ Frequency:_____

Notes_____

I certify that on the date listed here I have completed the above prescription information for student named.

Physician's Signature Date _