



Kearney Public Schools

Preschool, Elementary and Middle School

Health Questionnaire 2024-2025

Student's Last Name: _____ Student's First Name: _____

School: _____ Grade/Teacher: _____

Please select all valid responses:

	No	Yes	Please provide additional information
*Life Threatening Allergies			*must provide action plan
*Asthma / Breathing Difficulties			*must provide action plan
Cardiac / Heart condition			
Chronic Disease / Condition			
*Diabetic			*must provide action plan
*Seizures / Seizure condition			*must provide action plan
Food intolerance/sensitivity			*get meal accommodation form from Bearcat Diner

Is there any additional information about your child that the KPS nurse should know?

Do you have any psychiatric, behavioral, or emotional concerns regarding your child?

ANY medications your student may need at school MUST BE:

- Provided by family
- Stored in the Health Office
- In the original, labeled container
- Accompanied by a **Parental Request for In-School Medication** form (available on KPS website or at the school)

Doctor: _____ Phone Number: _____

Optometrist: _____ Phone Number: _____

I give permission to the school nurse to contact any of the providers listed above regarding my child's immunizations and/or physicals for the current school year. I also give permission to the school nurse to inform school relevant staff of medical conditions. I understand that all information will be kept confidential.

Parent /Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____