



Student ID Number: _____

STUDENT HEALTH FORM 2026-2027

Student's Legal Name: _____ Age: _____
Last First Middle

Grade: _____ School: _____ Birth Date: _____ Gender: _____

Medication/Supplements/Vitamins:

Does your student take medications/supplements/vitamins? No Yes Diagnosis/Reason _____

Medication/Supplements/Vitamins	Dose	Time(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information:

Physician's Name _____ Phone _____ Date of Last Visit _____

Dentist's Name _____ Phone _____ Date of Last Visit _____

Hospital Preference _____

Does your child have Health Insurance Coverage (commercial, self-pay, MO Health, etc.) No Yes

If yes, put name of insurance company your child has health insurance coverage with. If no, please see the School Outreach flyer.

Has your child had or does your child have any of the following?

- Allergies No Yes
If yes, please note and explain below whether it is food, environmental, medication, animals, other, use all that apply
- Asthma No Yes
If yes, Name of Inhaler _____
- Attention Deficit/Hyperactive Disorder No Yes
If yes, Name of Medication _____
- Behavior Concerns No Yes
- Bladder Concerns No Yes
- Bowel Concerns No Yes
- Broken Bones No Yes
- Chicken Pox Disease (mm/dd/yyyy) _____ No Yes
- Diabetes ___Insulin ___Diet Controlled No Yes
- Head Injury/Concussion Year _____ No Yes
- Hearing Concerns No Yes
- Heart Concerns/Murmur No Yes
- Hospitalizations No Yes
(other than newborn)
- Injuries/Accidents No Yes
- Mental/Emotional Concerns No Yes
- Other Chronic Diagnosis No Yes
(i.e. migraine headaches, hemophilia, sickle cell anemia, autoimmune disorder, other) If yes, please explain below.
- Physical Limitations No Yes
- Seizure Disorder No Yes
- Surgery/Stitches No Yes
- Vision Concerns No Yes
If yes, please note and explain below whether it is glasses, contact, both, other concerns.

Please explain yes answers here:

**** NEW Students Enrolling in North Kansas City Schools ** PLEASE ATTACH a copy of current immunizations from the Physician or Clinic. Students will NOT BE PERMITTED TO ENROLL without proof of state required immunizations.**

Do you have any concerns about your student's health:

Emergency Benadryl Authorization:

I give the school nurse permission to administer Benadryl under a standing prescription order by a NKCS D advising physician during an emergency medical situation if there is a suspected allergy situation.

No Yes

X _____
SIGNATURE of Parent/Guardian/Other

Date

Verification:

In case of illness or injury of my student, I understand the school will attempt to contact parents or guardians first. Then they will contact other persons I have listed- who are authorized to receive information, make certain medical decisions and have my student released to their custody. If none is available, the school is authorized to make whatever arrangements are deemed necessary to maintain my student's health including, but not limited to, emergency medical treatment.

I am the legal Parent/Guardian of this student. No Yes _____ Initials

If you are not the legal Parent/Guardian of this student, state your relationship to this student. _____

I verify that the information provided on this form is accurate and current.

X _____
SIGNATURE of Parent/Guardian/Other

PRINTED Name of Parent/Guardian/Other

Date