

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	
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Student Address <i>(check if new)</i> <input type="checkbox"/>	City	State	Zip Code	Home Phone <i>(check if unlisted)</i> <input type="checkbox"/>	Family doctor's Name	Doctor's Phone	Child's Dentist	Dentist's Phone
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Parent/Guardian Name	Address	City	Home Phone	Child Lives with Y/N	Employed By	Work Phone and shift hours
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Parent/Guardian Name	Address	City	Home Phone	Child Lives with Y/N	Employed By	Work Phone and shift hours
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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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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: _____

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.

<u>MEDICATION (name)</u>	<u>DOSE</u>	<u>TIME or SITUATION</u> (When Given)	<u>WHO ADMINISTERS</u> (Child/Adult)	<u>WHERE KEPT</u> (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