Emergency/Health Form - Kenosha Unified School District No. 1 Student Last Name First Name Middle Name Birthdate School Parent's eMail Address Cell Phone Grade Student Address (check if new) State Zip Code Home Phone (check if unlisted ☐ Family doctor's Name Doctor's Phone Child's Dentist Dentist's Phone Parent/Guardian Name Address City Home Phone Child Lives with Y/N **Employed By** Work Phone and shift hours Parent/Guardian Name Address Home Phone Child Lives with Y/N Employed By Please list additional emergency contacts below in the order you wish them to be called: Work Phone and shift hours Name Address Home Phone Work Phone and Extension Relationship to Student Name Address Home Phone Work Phone and Extension Relationship to Student 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 wilhout 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: \_ Birth Defects, list/explain:\_\_\_ Currently in: Treatment Remission 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: Selzure Disorder, describe type:\_\_\_\_ Date of last seizure: Swallowing, Stomach or Intestinal disorders: Vision, Hearing or Speech problems, describe: Other, describe: Hearing Aids Ear Tubes ☐ Glasses \*\*\*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

SIGNATURE of Parent/Legal Guardian:

Date:

Language Used:

CALLESTICATION

CA

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. Me tion forms may be obtained from the school office.						
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