

KENAI PENINSULA BOROUGH SCHOOL DISTRICT
Student Health Review

STUDENT NAME _____ BIRTHDATE _____ GRADE _____
SCHOOL _____

For ADDITIONAL COMMENTS please use the back of the form.

1. **LAST PHYSICAL EXAM:** Date _____ Doctor _____ Clinic Name/Location _____

2. **LAST DENTAL EXAM:** Date _____ Doctor _____ Clinic Name/Location _____

3. **LAST VISION EXAM:** Date _____ Doctor _____ Clinic Name/Location _____

4. **CURRENT MEDICATIONS** Medication(s) to be taken at School _____ (Additional form required.)
Medication(s) taken at Home (include non-prescriptive medications taken on a regular basis) _____

5. **LAST SCHOOL ATTENDED:** _____ **PERMISSION FOR EMERGENCY CARE** YES NO

6. **ALLERGIES:** NO YES – if yes, please list specific allergies below. Use the back of the form as needed.

MEDICATION(S) _____
What happens if your child takes this? _____
How do you treat? _____

BEES, INSECTS, SPIDERS, etc. _____
What happens if your child is stung or bitten? _____
How do you treat? _____

FOOD and/or DRINK* _____
What happens if your child eats this? _____
How do you treat? _____ *School Lunch substitutions require a doctor's request.

ANIMALS _____
What happens if your child comes in contact with this animal? _____
How do you treat? _____

OTHER (please list) _____
What happens if your child comes in contact with this? _____
How do you treat? _____

7. **CURRENT MEDICAL INFORMATION:** Mark any ongoing conditions and concerns.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> asthma* | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> vision concerns | <input type="checkbox"/> knee, back, bone or joint concerns |
| <input type="checkbox"/> other respiratory concerns | <input type="checkbox"/> frequent nosebleeds | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> muscular concerns |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> frequent stomachaches | <input type="checkbox"/> dental pain or concerns | <input type="checkbox"/> mental/emotional concerns |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> frequently complains of being sick | <input type="checkbox"/> speech concerns | <input type="checkbox"/> skin concerns |
| <input type="checkbox"/> seizures | <input type="checkbox"/> ear/hearing concerns | <input type="checkbox"/> urinary/bowel concerns | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> previous head injury with unconsciousness* | <input type="checkbox"/> tubes in place | | |
- *additional forms may be requested
For **COMMENTS** use the form back.

CURRENT SPECIFIC MEDICAL DIAGNOSIS: NO YES

Diagnosis _____ Doctor _____ Clinic Name/Location _____
Date Identified _____ Care/treatment required at school _____

CURRENT PHYSICAL ACTIVITY LIMITATIONS _____

8. **PAST MEDICAL INFORMATION: Operations, injuries, hospitalizations, and past medical concerns, including birth information and history of developmental delays as appropriate (please include dates):** _____

9. **ADDITIONAL INFORMATION:** Please add any additional information helpful to the school staff (i.e., family, learning, special needs)

My signature allows for information that pertains to school safety or helps my child in the classroom to be shared with additional school staff as appropriate.

PERSON COMPLETING THIS FORM: _____
(Name) (Relation to child) (Today's Date)