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. **<u>CURRENT</u> MEDICAL INFORMATION:** Mark any ongoing conditions and concerns.

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

<u>CURRENT</u> SPECIFIC MEDICAL DIAGNOSIS: NO YES

Diagnosis: _____ Doctor: _____ Clinic Name/Location: _____

Date Identified: _____ Care/treatment required at school: _____

CURRENT PHYSICAL ACTIVITY LIMITATIONS: _____

8. **<u>PAST</u> MEDICAL INFORMATION: Operations, injuries, hospitalizations, and past medical concerns, including birth information and history of developmental delays as appropriate (please include dates):** _____
_____ **(may use back of form)**

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)

ADDITIONAL INFORMATION PAGE – USE AS NEEDED

ADDITIONAL ALLERGY INFORMATION

ADDITIONAL BIRTH HISTORY and PRE-SCHOOL INFORMATION - optional

Circle any that apply and comment as necessary.
Birth: Full Term Premature If premature, how may weeks?
Delivery: Home Delivery Hospital Delivery Difficult Delivery Normal Delivery
Weight at Birth:
Developmental Delays (please identify):
Operations (please list):
Major injuries and/or illnesses (please list):

ADDITIONAL COMMENTS