Excelsior Springs School District
Health Enrollment form

PLEASE PRINT

Students name:_____

Date: _____ Grade _____ Date of Birth:_____ Age:_____ Gender:_____

As a convenience to the patrons of our school district, "First Aid" will be administered on a limited basis, through the Health Office in the Excelsior Springs School District. If your child requires routine medications, please notify the Health Office.

In the event of a life threatening emergency, your child may be administered Albuterol (0.09 mg/puff) via inhaler or Albuterol (2.5mg per 3 ml) via nebulizer and/or Epinephrine via Epi-pen. If administration is required, calls will be made to both 911 and parents. If an injury or illness requires immediate attention and the school is unable to locate the parent, emergency care will be provided by school /emergency medical personnel and the student may be taken to a hospital emergency room. The school district is not responsible for the subsequent treatment or medical expenses incurred after administration of first aid. If you do not wish for these medications to be given, please notifiy the school health room for an OPT OUT form.

_____

X Legal Responsible Person (please print name)

_____Date____/____/____

X Signature of Responsible Person

Does your child have specific health limitations/needs that would require special consideration at school or wear **glasses/contacts** If yes, please explain:

_____

Does your child have any of the following illnesses? Please circle all that apply:

Asthma - Diabetes - Seizures - Heart Condition - Migraines - ADD/ADHD- Vision - Hearing - Mental

If your child has asthma, diabetes, seizure, food, drug or environmental allergies, your child will need to be seen by a physician and an ACTION PLAN for that diagnosis will need to be provided to the school. If your child has any medications, either prescribed or over the counter that you wished administered at school, even if your child is self administering, we will need a medication consent form signed.

If your child will be carrying an inhaler or diabetic medications and equipment for self administration, we will need a consent to carry form filled out and signed.

If your child requires routine medications, please notify the Health Office.

- **Does student have any specific condition alert/illness/physical problem that might affect their academic or physical activity at school? _____Yes _____No**

If yes, please list below

Medical diagnosis_____medication_____

Medical diagnosis_____medication_____

Medical diagnosis_____medication_____

Medical diagnosis_____medication_____

The "Safe School Act" requires documentation from the student's physician in order for the student to carry their inhaler. It is highly recommended a second inhaler be kept in the health office as a back up. Please pick up the proper forms in the Health Office.

____ Allergy to: (**Foods**) (Peanut butter, nuts, etc.)

ListFoods:_____DegreeofReaction(s):_____

NOTE: STUDENT MUST HAVE "YEARLY" WRITTEN DOCUMENTATION OF "FOOD ALLERGY" AND AN ACTION PLAN FOR STUDENT, FROM STUDENTS PHYSICIAN, REGARDING ANY FOOD-PEANUT BUTTER-NUT ALLERGY. THIS MUST BE ON FILE IN THE HEALTH OFFICE.

____ Allergy to: (**Medications**)**List Medication(s):** _____**Reaction(s):** _____

____ Allergy to: (**Bites/Stings**)**List Bites/Stings:** _____**Reaction(s):**_____

____ Allergy to: (**Seasonal/Environmental**/trees, pollen, pets)_____**Reaction(s)**_____ ____ Milk Intoler

NOTE: IN ORDER FOR A STUDENT NOT TO HAVE MILK ON THEIR LUNCH TRAY AND/OR RECEIVE A MILK SUBSTITUTE, STUDENTS WITH A MILK/DAIRY INTOLERANCE MUST HAVE YEARLY WRITTEN DOCUMENTATION, FROM THEIR PHYSICIAN, REGARDING MILK ALLERGY AND AN ACTION PLAN, ON FILE IN THE HEALTH OFFICE.

Does student have private insurance? Yes / No Medicaid? Yes / No Medicaid #: <<Medicaid Number>>

Doctor's Name: _____Phone_____Seen in the last 12 months? Yes / No (circle one)

Dentist's Name: _____Phone_____Seen in the last 12 months? Yes / No (circle one)

Eye Doctor's Name: _____Phone_____ Seen in the last 12 months? Yes / No (circle one)

Hospital Preference _____

(Updated 10/15)