

**USD 377 ATCHISON COUNTY COMMUNITY SCHOOLS  
HEALTH HISTORY AND MEDICAL INFORMATION FORM**

Name of Student: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**HEALTH & MEDICAL INFORMATION**

Yes  No **Attention Deficit Disorder (ADD/ADHD)**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Yes  No **Allergies** (If Yes, check below and explain)

Food  Insect bites/stings  Pollens  Animals  Medication

Explain: \_\_\_\_\_

Will the student use an Epi-Pen at school:  Yes  No

Yes  No **Asthma**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Will the student use an inhaler at school:  Yes  No

Yes  No **Bone/Muscle Condition**

Explain: \_\_\_\_\_

Yes  No **Diabetes – (Complete Kansas Diabetes Health Care Plan)**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Yes  No **Ear or Throat Infections, Chronic**

Explain: \_\_\_\_\_

Yes  No **Emotional Problems**

Counseling:  Yes  No Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Yes  No **Fainting** - Has the student ever experienced a sudden loss of consciousness (If Yes, explain below)

Explain: \_\_\_\_\_

Yes  No **Frequent Headaches or Migraines**

Treatment:  Yes  No Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Yes  No **Head Injuries or Major Accidents of any kind**

Explain: \_\_\_\_\_

Yes  No **Heart, Blood Disease or High Blood Pressure**

Explain: \_\_\_\_\_

Yes  No **Hearing Loss**

Degree of Impairment: \_\_\_\_\_ Hearing Aid:  Yes  No

Yes  No **Physical Handicap**

Explain: \_\_\_\_\_

Yes  No **Seizure Disorder**

Type of Seizure: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Yes  No **Skin Problems**

Explain: \_\_\_\_\_

Yes  No **Urinary/Bowel Condition**

Explain: \_\_\_\_\_

Yes  No **Vision Problems** (If Yes, please check below)

Glasses  Contact lenses  Wears all the time  Wears some of the time

Eye surgery (Explain): \_\_\_\_\_

Yes  No **Daily medication** Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

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Other Health Concerns Including Hospitalizations or Operations Not Previously Mentioned: \_\_\_\_\_

Is there anything at this time you would like to discuss with the school nurse? \_\_\_\_\_

**MEDICAL EMERGENCY PERMISSION**

Yes  No      In case of emergency, illness or accident, to the student named above, and in the event the parents cannot be reached, I give permission to call the family physician and permission to treat the child and permission to consult with another physician if the family physician cannot be reached.

For the safety and well-being of your child, this medical information will be released to school personnel working with your child.

A signed USD 377 Atchison County Community Schools Enrollment form is on file with emergency contact information. In case of serious accident or illness at school, your child will be sent to an emergency medical facility. The parent(s)/guardian(s) is responsible for all expenses.

All medications given at school (over-the-counter or prescription) must have a signed consent form from the doctor and parent on file before medication will be given at school.

Date: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Printed Name of Parent/Guardian**