

**USD 428 STUDENT HEALTH FORM**

STUDENT'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_

**I give my consent for the immunization record to be released to the Kansas Immunization Program and/or health care agencies for the purpose of assessment and reporting.**

Parent/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY**

- Asthma \_\_\_\_\_
- Potentially severe allergic reaction (explain) \_\_\_\_\_
- Diabetes Insulin dependent YES \_\_\_\_\_ NO \_\_\_\_\_ Non insulin dependent YES \_\_\_\_\_ NO \_\_\_\_\_
- Hypoglycemia (Low blood sugar) On special diet? YES \_\_\_\_\_ NO \_\_\_\_\_
- Bone or joint injury (explain) \_\_\_\_\_
- Seizures (explain) \_\_\_\_\_
- Ulcer or stomach problems (explain) \_\_\_\_\_
- Headaches \_\_\_\_\_
- Wears glasses/contacts \_\_\_\_\_ Eye problems (explain) \_\_\_\_\_
- Hearing loss (explain) \_\_\_\_\_
- Heart conditions (explain) \_\_\_\_\_
- Attention deficit hyperactivity disorder (ADHD)  Attention Deficit disorder (ADD)
- Other health problems not mentioned above \_\_\_\_\_
- No known health problems

Current Medications	Dosage/Frequency	Doctor	Medication given at school(yes/no)
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