Health Information Form
USD #467
Wichita County School District
Leoti, KS 67861

Dear Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. State law requires complete primary immunizations and health assessment (for all students age 9 and under) by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor **prior** to school entrance. As per Kansas Statute 72-5209, all children upon entry to school **must be appropriately vaccinated.** Medical and/or religious exemption forms may be obtained at any local health department, clinic, school nurse or local department of social services. Medical exemptions must be documented annually on KCI Form B.

Student's Name: ______________________________ Current Grade: ________

Student's Date of Birth: ________________ Sex: _____ Home Language: _______

Student's Address: ________________________ City: __________ State: _____

Mother's Name: __________________________ Phone: ____________________

Father's Name: __________________________ Phone: ____________________

Legal Guardian: __________________________ Phone: ____________________

Emergency Contact: _______________________ Phone: ____________________

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head or Spinal Injury		
Asthma or breathing problems			Hearing Problems or Deafness		
Attention-Deficit / Hyperactivity Disorder			Heart Problems		
Behavior Problems			Hospitalizations		
Developmental Problems			Lead Poisoning		
Bladder Problems			Muscle Problems		
Bleeding Problems			Seizures		
Bowel Problems			Sickle Cell Disease (Not Trait)		
Cerebral Palsy			Speech Problems		
Chicken Pox		Date:	Surgery		
Cystic Fibrosis			Visual Problems		
Dental Problems					

Describe any other important health-related information about your child:

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Check here if you want to discuss confidential information with the school nurse or other school authority. Yes _____ No _____

	Name	City	Phone	Date-last appt
Primary Healthcare Provider				
Specialist				
Primary Dentist				
Specialist				
Case Worker (if applicable)				

List all prescription, over-the-counter, and herbal medications your child takes regularly.

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I, __________________________, (do _____) (do not _____) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until you withdraw it. You may withdraw your authorization at any time by contacting your school (in writing). When information is released from your child's record, documentation of the disclosure is maintained in your child's health and/or scholastic records.

______________________________________ ______________

Signature of Parent or Legal Guardian Date

______________________________________ ______________

Signature of Person Completing Form Date

______________________________________ ______________

Signature of Interpreter Date