KENT SCHOOL HEALTH INFORMATION

STUDENT NAME: ____

BIRTHDATE: __________ AGE: ______ GRADE: _______

HOME MAILING ADDRESS: ______________________________
____

HOME PHONE: __________________________________

MOTHER/GUARDIAN'S NAME: ____________________________

FATHER/GUARDIAN'S NAME: _____________________________

MOTHER'S WORK# __________ FATHER'S WORK# __________

CELL #: ____________________ CELL#: ______________________

IF UNABLE TO REACH PARENT(S):

#I EMERGENCY CONTACT: ________________________________

RELATIONSHIP: _________HOME #: ______ WORK #: ______

#2 EMERGENCY CONTACT: ______________________________

RELATIONSHIP: ________ HOME #: ______ WORK #: ______

HEALTH CARE / INSURANCE INFORMATION:

FAMILY PHYSICIAN: ______________ DENTIST: ____________

PHONE #: _____________________ PHONE #: ______________

PRIVATE INSURANCE: ____________ POL #: ______________

LAST MEDICAL EXAM: ____________ BY DR.: _____________

LAST DENTAL EXAM: _____________ BY DR.: _____________

CIRCLE THOSE WHICH APPLY TO YOUR CHILD

Asthma/Breathing Problems Diabetes Epilepsy/Seizures
Ear Infections/Tubes In Ears Hearing Problems Stomachaches
Vision Problems Headaches Speech Problems Nosebleeds
Bone/Joint/Muscle Problems Heart Disease Skin Problems
Blood Disorders/Sickle Cell High Fevers Birth Defects
Attention/Hyperactivity Disorder Other: ______________________

Handicaps: ____

Has your child had chicken pox? ______________________________

List any operations, injuries, hospitalizations and dates/reasons:

____

Allergies: Drug ______________Food ________________

Environmental Bee/insect: ______________________________

Explain Reaction: ______________________________________

Does your child require emergency medication? _______

Name of Medicine _____________________________________

Does your child take medications including inhalers prescribed by a physician every day? Yes No

If yes, what medication? ______________Reason __________

Physical Education: Does your child have a condition that currently or periodically restricts his/her physical activity? Yes No

Other: Does your child wear glasses? Yes No Contacts? Yes No
Does your child wear hearing aides? Yes No

All medications must be brought to school by the parents and given to Mrs. Nickerson. **This should include proper labeling, <u>physician's order sheet and parent's signature</u>.** Children cannot transport medication on the bus (prescription or non prescription).

We will use the following procedure if your child becomes sick or injured at school:

- Call home. If there is no answer, we will call your place of employment.
- If we cannot reach you at work, we will call the emergency numbers listed and your physician, if need be.
- If necessary your child will be transported to a medical facility by the most appropriate means.

If I cannot be reached and the school authorities have followed the procedure described, I hereby consent to any treatment deemed necessary by the attending physician.

Parent/Guardian: _________________________ Date ___________

PERMISSION FOR FIELD TRIPS

__________________________________ has my permission to go on any trips arranged by Kent School. I understand that I will be notified of plans for these trips in advance.

Parent/Guardian _______________________ Date _____________

****

PERMISSION FOR PHYSICAL EDUCATION

__________________________________ has my permission to participate in all physical education activities.

Parent/Guardian _______________________ Date _____________

****

For all school correspondences please supply us with one email address:

____