Kingsland Public Schools Student Health Survey

Student Last Name_____ Student First Name_____

Age _____ Gender ____ Current Grade _____

Student's Physician _____ Physician's Phone _____

Please provide the following information for the purpose of initiating or updating your child's health record.

General Health (check one): ☐ Excellent ☐ Good ☐ Other (explain below)

Please check any conditions which apply to your child:

☐ **Allergies** Triggers: _____ Treatment: _____

☐ **Asthma** Triggers: _____ Treatment: _____

☐ **Diabetes** Management Plan at School: _____

☐ **Hearing Impairment** Hearing Aids: ☐ Yes ☐ No

☐ **Injuries** (severe or which had lasting effects (including concussion/head injury)

_____

☐ **Medication** (on a regular basis at school)
**You will need to fill out a separate OTC or prescription form for each medication.*

List medication(s): _____ _____

_____ _____

☐ **Seizure Disorder** Medication: _____

☐ **Special Diet** (fill out Special Diet Form, with OR without disability)

☐ **Vision Impairment** ☐ Glasses ☐ Contacts

☐ **NO Health Concerns**

Please describe in further detail any condition which you checked above:

_____

_____

I give permission for this information to be shared with:

☐ Health Office Staff only ☐ Classroom Teacher ☐ Any staff responsible for my child.

Parent Signature: _____ **Date:** _____

KINGSLAND PUBLIC SCHOOLS
EMERGENCY MANAGEMENT PLAN

Dear Parents/Guardians:

We understand that your child has _____which could require emergency medication and/or care. In order to plan for your child's care, we need the following information. Please discuss this with your physician and child so that you all understand and agree about what will happen in the event of an emergency. School personnel cannot give injections, so if adrenaline is needed it must be in an automatic injectable syringe, such as an Epi-pen. 911 will be called if an Epi-pen is administered. 911 will also be called for other emergency situations.

Child's Name: _____ DOB: _____ Grade: _____

Home Address: _____ Phone: _____

Parent/Guardian Names: _____ Daytime Phone: _____

_____ Daytime Phone: _____

Emergency Contact (if parents unavailable): _____ Phone: _____

PROCEDURE

Condition that requires emergency care:
_____

Describe what might occur:
_____

List in order the sequence of things that should be done for your child: (i.e. call 911, give Epi-pen, call parents, give other medications, apply ice pack, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Physician's Name: _____ Phone: _____

Address: _____

I request the above procedure be followed for my child.

Parent/Guardian Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

Please note: A separate form for the administration of medication must also be included if medication is part of the plan. (Medication form returned - Date: _____)