Emergency/Health Form – Kenosha Unified School District No. 1

YR: ID#

Student Last Name	First Name	Middle Name	Birth date	School	Grade	Parent's Email Address	Cell Phone	**Bus#**

Student Address (check if new) ☐	City	State	Zip Code	Home Phone (check if unlisted) ☐	Family Doctor's Name	Doctor's Phone	Child's Dentist	Dentist Phone

Parent/Guardian Name	Address	City	Home Phone	Cell Phone	Child Lives with Y/N	Employed by	Work Phone & shift hours
Parent/Guardian Name	Address	City	Home Phone	Cell Phone	Child Lives with Y/N	Employed by	Work Phone & shift hours

Please list additional emergency contacts below in the order you wish them to be called:

Name	Address	Home Phone	Cell Phone	Work Phone and Ext	Relationship to Student
Name	Address	Home Phone	Cell Phone	Work Phone and Ext	Relationship to Student

Confidential Health Information If your child's doctor has told you your child has any of the problems noted below, please "**X**" all that apply and answer questions related to problem.

☐ My child has no known health problems ☐ **MY CHILD'S HEALTH CONDITION IS POTENTIALLY LIFE THREATENING**

☐ **Attention Deficit Disorder** with or without hyperactivity ☐ Does your child have a form of Autism? If yes, describe: ____________________

☐ **Allergies**, Types: ☐Foods, list foods: ____________________

☐Bees, Wasps/Other Insects ☐Latex/Rubber ☐Allergies to medications: (List here) ____________________

☐ Other, please describe ____________________

☐ **Asthma** or other breathing problems, describe: ____________________

☐ **Conditions or problems that affect walking or movement**, describe: ____________________

☐ **Cancer**, Type: ____________________ Currently in: ☐ Treatment ☐ Remission

☐ **Birth Defects**, list/explain: ____________________

☐ **Blood Disorder** other than HIV/AIDS (i.e. Sickle Cell), describe: ____________________ ☐Elevated Lead Level

☐ **Diabetes** (Circle) **Type 1** or **Type 2** List types of insulin, dose and times taken on back.

☐ **Emotional/Psychological problems**, describe: ____________________

☐ **Heart Condition**, describe: ____________________

☐ **Nerve Disorders** other than seizure/epilepsy, describe: ____________________

☐ **Organ Transplant**, list organ: ____________________

☐ **Seizure Disorder**, describe type: ____________________

☐ **Swallowing, Stomach or Intestinal** disorders: ____________________

☐ **Vision, Hearing, or Speech** problems, describe: ____________________ ☐ Hearing Aids ☐ Ear Tubes ☐ Glasses

☐ **Other**, describe: ____________________

***** PLEASE LIST ALL MEDICATIONS AND/OR TREATMENTS ON THE BACK OF THIS FORM *****

8-2146 (Rev. 02/2012)

CONTINUED ON BACK

STUDENT NAME: ______________________________________

MEDICATION (List names of all medications child takes, doses and times given):
Each medication given at school requires written parental consent. Each prescription medication requires a physician's written order and written parental consent. Medication forms may be obtained from the school office.

MEDICATION (name)	DOSE	TIME OR SITUATION (when given)	WHO ADMINISTERS (child/adult)	WHERE KEPT (Home / School / Backpack…)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

I do ☐ I do not ☐ give permission for the principal or his/her designee to contact any of the emergency contacts I have provided if my child becomes ill at school and you cannot reach me by phone.

I do ☐ I do not ☐ give permission to contact the Student's Physician for consultation if needed.

I do ☐ I do not ☐ give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

If a serious illness or accident occurs at school, I understand that my child will be sent by rescue squad to the emergency room. (All expenses charged by the hospital are the responsibility of the Parent/Guardian.)

This form is complete and accurate to the best of my knowledge.

SIGNATURE of Parent/Legal Guardian: ______________________ **Date:** ____/____/____ **Language spoken at home?** ______________