KUNA JOINT SCHOOL DISTRICT #3

ELEMENTARY HEALTH HISTORY

Kindergarten through 3rd Grade

STUDENT'S NAME:_____BIRTHDATE:_____

Lives with:_____ ☐Mom ☐Dad ☐Guardian

Information provided by:_____ ☐Mom ☐Dad ☐Guardian

Today's Date _____ Grade _____ Gender ☐Female ☐Male

PLEASE CHECK THE FOLLOWING HEALTH CONCERNS THAT APPLY:

☐ ALLERGIES:
- ☐ Bee/insect sting: ☐Call 911 if stung ☐ swells at site only
- ☐ Medicine: _____reaction_____
- ☐ Food: _____ reaction_____
- ☐ Environmental:_____ reaction_____

☐ ASTHMA: What starts an attack? ☐exercise ☐colds ☐allergies, list_____
☐smoke ☐other, list _____
List asthma medications _____

☐ VISION: ☐contacts ☐glasses ☐vision loss ☐color blind ☐other _____
Date of last exam_____

☐ HEARING: ☐hearing loss, describe _____
☐frequent ear infections ☐hearing aids

☐ DIABETES: ☐insulin dependent ☐non-insulin dependent

☐ HEART PROBLEMS: list _____

☐ EATING/DIGESTION PROBLEMS: _____

☐ MUSCLE/JOINT/BONE PROBLEMS: _____

☐ KIDNEY/BLADDER CONCERNS: _____

☐ SEIZURES: type _____ frequency _____ medication _____

☐ ATTENTION DEFICIT DISORDER: ☐in counseling ☐on medication, list_____

☐ EMOTIONAL CONCERNS: list _____

☐ HEADACHES/MIGRAINES: frequency _____ treatment _____

☐ PAST SURGERIES _____

☐ PAST MAJOR ILLNESSES/INJURIES _____

☐ MEDICATIONS: ☐taken at home, list _____
☐**taken at school, list** _____
Times_____amounts_____

☐ OTHER: _____
_____

We hereby consent to the treatment of our minor child by a medical physician or medical personnel at any hospital OR to temporary treatment by a registered nurse, licensed practical nurse or emergency medical technician until a medical physician can be obtained for any illness or injury to our minor child while on or adjacent to any school grounds of the Kuna Joint School District. This consent shall include, but not be limited to, any surgery deemed required or desirable for immediate health or medical treatment of our child.

_____ _____
Parent/ Guardian Signature Date