KNOXVILLE CSD ANNUAL HEALTH HISTORY PK-12

Student's Name (Last, First)_____ Grade in Fall: _____

Age: _____ Date of Birth_____ Sex: Male: _____ Female: _____

Parent/Guardian 1 name: _____ Cell phone: _____

Parent/Guardian 2 name: _____ Cell phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

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HEALTH HISTORY: PLEASE MARK THE ONES THAT APPLY TO YOUR CHILD

Allergies:
Medications, Seasonal, or Food_____ **Epi-pen for school? YES / NO**
What is the **reaction** your child has when exposed to the allergen (swelling, hives, vomiting, etc.)
_____
(**FORM REQUIRED** for meal modifications at school for **Diet Modification Request Form**)

Asthma _____ **Triggers?** _____**Inhaler needed at school? YES / NO**
(**FORM REQUIRED** for student to self-carrying inhaler: **Asthma Medication Self-Administration Form**)

Heart Condition_____**Migraine headaches**_____ **Treatment** _____

Diabetes _____ Insulin_____ Insulin Pump_____ **Seizures** _____ **Arthritis** _____

Hearing Concerns_____ Aides_____ **Vision Concerns** _____ Glasses _____ Contacts _____

ADHD _____ **Autism** _____ **OTHER** _____

Medications:
Prescribed medications taken at **home:** _____
Prescribed medications to be taken at **school:**_____
(**FORM REQUIRED** for meds to be given at school: **MEDICATION AUTHORIZATION and PERMISSION**)

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their child can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent, or legal guardian, of the child named _____, I authorize emergency medical treatment that is necessary in the event of an accident or illness of my child. I understand that this written consent is given in advance of any specific diagnosis or hospital care. This written authorization is granted only after a reasonable effort has been made to contact me. **Parent/Guardian signature:** _____ **Date:** _____