KENAI PENINSULA BOROUGH SCHOOL DISTRICT
Student Health Review

STUDENT NAME _____ BIRTHDATE _____ GRADE _____
SCHOOL _____

For ADDITIONAL COMMENTS please use the back of the form.

1. **LAST PHYSICAL EXAM:** Date _____ Doctor _____ Clinic Name/Location _____

2. **LAST DENTAL EXAM:** Date _____ Doctor _____ Clinic Name/Location _____

3. **LAST VISION EXAM:** Date _____ Doctor _____ Clinic Name/Location _____

4. **CURRENT MEDICATIONS** Medication(s) to be taken at School _____ (Additional form required.)
Medication(s) taken at Home (include non-prescriptive medications taken on a regular basis) _____

5. **LAST SCHOOL ATTENDED:** _____ **PERMISSION FOR EMERGENCY CARE** ☐ **YES** ☐ **NO**

6. **ALLERGIES:** ☐ **NO** ☐ **YES** – if yes, please list specific allergies below. Use the back of the form as needed.

MEDICATION(S) _____
What happens if your child takes this? _____
How do you treat? _____

BEES, INSECTS, SPIDERS, etc. _____
What happens if your child is stung or bitten? _____
How do you treat? _____

FOOD and/or DRINK* _____
What happens if your child eats this? _____
How do you treat? _____ *School Lunch substitutions require a doctor's request.

ANIMALS _____
What happens if your child comes in contact with this animal? _____
How do you treat? _____

OTHER (please list) _____
What happens if your child comes in contact with this?
How do you treat? _____

7. **CURRENT MEDICAL INFORMATION:** Mark any ongoing conditions and concerns.

☐ asthma*	☐ frequent headaches	☐ vision concerns	☐ knee, back, bone or joint concerns
☐ other respiratory concerns	☐ frequent nosebleeds	☐ wears glasses/contacts	
☐ diabetes	☐ frequent stomachaches	☐ dental pain or concerns	☐ muscular concerns
☐ heart disease	☐ frequently complains of being sick	☐ speech concerns	☐ mental/emotional concerns
☐ seizures	☐ ear/hearing concerns	☐ skin concerns	☐ other _____
☐ previous head injury with unconsciousness*	☐ tubes in place	☐ urinary/bowel concerns	*additional forms may be requested For **COMMENTS** use the form back.

CURRENT SPECIFIC MEDICAL DIAGNOSIS: ☐ **NO** ☐ **YES**

Diagnosis _____ Doctor _____ Clinic Name/Location _____
Date Identified Care/treatment required at school _____

CURRENT PHYSICAL ACTIVITY LIMITATIONS _____

8. **PAST MEDICAL INFORMATION: Operations, injuries, hospitalizations, and past medical concerns, including birth information and history of developmental delays as appropriate (please include dates):** _____

9. **ADDITIONAL INFORMATION:** Please add any additional information helpful to the school staff (i.e., family, learning, special needs)

_____

My signature allows for information that pertains to school safety or helps my child in the classroom to be shared with additional school staff as appropriate.

PERSON COMPLETING THIS FORM: _____
(Name) (Relation to child) (Today's Date)