School District of Kettle Moraine

Annual Health and Emergency Information

Please verify health and emergency information.

STUDENT				
Student Legal Name *(as it appears on birth record or other legal document)*			***School*** _____	
Last Name	*First Name*	*Middle (full)*	*Suffix (Jr., II, III)*	*Nickname*
Gender	*Birth Date*	*Age*	*Grade*	

MEDICAL PROVIDERS	
Physician Name	**Physician Phone Number**
Dentist Name	**Dentist Phone Number**

HOSPITAL

Indicate preferred hospital. However, be advised that in an emergency, transport will be at the discretion of the responding EMS.

☐ **Oconomowoc Memorial** ☐ **Waukesha Memorial** ☐ **Aurora Summit**

HEALTH CONCERNS

☐ **NO KNOWN HEALTH CONCERNS**

☐ **DIABETES**
- ☐ insulin dependent
- ☐ non-insulin dependent

☐ **SEIZURE DISORDER**
Most Recent Seizure_____
Medication at home_____
Medication needed at school_____

☐ **SEVERE ALLERGIC REACTION**
Allergic to_____
Describe reaction_____
Emergency medication needed at school_____
_____

☐ **ALLERGIES** that may impact school performance or attendance.

Food_____
Insect bite/sting_____
Latex_____
Other

☐ **ASTHMA**
☐ mild ☐ moderate ☐ severe
Medication at home_____
Medication needed at school_____

☐ **OTHER HEALTH CONDITION** (or medical history staff should be aware of the event of an emergency).
_____
_____

If your student will require medication at school, complete the Medication Authorization Form. (Available on the district website.)

Immunizations received during past year:

Vaccine				
Date MM/DD/YYYY				

DISCLOSURE: I understand that the information contained on this form will be kept confidential, but may be made available by the school nurse to school staff to ensure the health and safety of this student. This information will also be shared with emergency medical staff in the event of a health or safety emergency necessitating transport to a medical facility.

_____	_____
PARENT SIGNATURE	DATE

THIS INFORMATION WILL BE KEPT ON FILE AS CURRENT UNLESS RESCINDED BY PARENT/GUARDIAN.

This form is complete and accurate to the best of my knowledge. By signing this form I give permission to share my child's immunization records with the Wisconsin Immunization Registry and my Immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here if you do not give your permission. ☐