Kiel Area School District Medical History for Summer School – Pupil Emergency Information

****IF YOUR CHILD CURRENTLY ATTENDS THE KASD you do not need to complete the Medical History, as we have your information on file. Please do, however, sign the authorization for emergency referral/transportation at the bottom. Thank you!*

Child's Name: ____

Home Address: ____

Father's Employer: ______________________ Phone*: ______________

Mother's Employer: ______________________ Phone*: ______________

*Please list phone numbers where you can be reached during the school hours and any cell phone numbers.

If you cannot be reached, who do you want notified:

Name: ______________________________ Phone: ______________

Relationship: ______________________________ Other Phone: ______________

Physician: ______________________________ Phone: ______________

Clinic: ____

Medical History:

Does the student have a history of?

Condition	Yes	No
Allergies (see info to the right)		
Asthma		
Cerebral Palsy		
Chronic Skin Problems		
Diabetes		
Epilepsy		
Headaches		
Heart Problems		
Kidney Problems		
Orthopedic Problems		
Other (please specify)		
Vision Problems		
Wears Glasses/contacts		
Hearing Problems		

Allergies		
Medical Alert Information (check any that apply)		
Bee Stings		
Environment		
Foods		
Medicines		
Other:		
Other:		
Other:		
Other:		
Is treatment needed for allergy:	**Yes**	**No**
Please Explain:		

IEP or Special Services		
	Yes	**No**
ED		
ID		
LD		
Speech:		
ELL:		
Title I		
Other:		
Please Explain:		

Within the last 12 months has your child had:

	Yes	No	Comments
Surgery			
Skull Fracture			
Serious Illness			
Serious Accident			
Diagnosed concussion			

AUTHORIZATION FOR EMERGENCY REFERRAL AND MEDICAL TREATMENT/TRANSPORT

As parents of ______________________, we authorize school personnel to refer our child to our family doctor in the event we cannot be readily contacted, and authorize the doctor to treat the child. If either our doctor or we cannot be reached and/or the situation is recognized by the attending adult as emergent, we give the school permission to arrange transportation for our child to the nearest medical facility. **We agree to assume all costs involved, including possible ambulance fees.**

Parent/Guardian Signature______________________________ Date: ______________