MUKWONAGO AREA SCHOOL DISTRICT—HEALTH SERVICES
DISTRICT NURSE PHONE: 262-363-6292 X27515 FAX: 262-363-6320

REQUIRED ANNUALLY

Student Health Information 2016-2017

Student Name: _____ Date of Birth: _____ Grade _____

Parent / Guardian Name: _____ Day time phone: _____

Health Care Provider's Name: _____ Phone: _____ Fax: _____

Does your child have any special health concerns? ☐ Yes ☐ No

☐ Asthma* ☐ Diabetes* ☐ Seizure Disorder* ☐ Other* _____

Does your child have any *Severe Allergies*? ☐ Yes ☐ No

	List allergic item(s):	Describe Reaction:	Date of Last Reaction
☐ Food(s)*			
☐ Insect(s)*			
☐ Latex*			
☐ Medication(s)			
☐ Other			

* *A **Health Care Plan** must be filled out every year for the above health concerns and allergies. Forms may be obtained from school health office or district website under printable forms to provide special instructions for staff.*

Comments: _____

_____

_____

_____

Is your child currently taking medication? ☐ Yes ☐ No

Name of medicine(s) _____

Reason(s) _____

_____

Will medication be taken at school? ☐ Yes ☐ No

** If yes, obtain **Authorization of Medication form** from school health office or district website under printable forms.*

A ***concussion*** can impact your child's learning and education. It is important to notify your child's school if they sustain a head injury that results in a concussion anytime during the school year. Most concussions will resolve within a week, but some may have more long term effects. Please see the district website under health services for information on signs and symptoms of a concussion. Health Service website http://www.masd.k12.wi.us/masd-health-student.cfm

The above information may be shared with all Mukwonago Area School District personnel and school bus drivers as needed to provide for student well-being at school. If a situation occurs in which my child needs immediate medical attention and I am unavailable to give consent, this signed statement will serve as authorization for school personnel to obtain medical care in the best interest of my child until I can be contacted. I understand that every effort will be made to contact me prior to initiating care. I understand it is my responsibility to keep the school updated on changes in contact numbers by completing change/addition on student/household information forms. I also understand that any expenses for emergency transport and/or care are my responsibility.

Parent/Guardian Signature _____ Date _____

OFFICE: DISTRIBUTE TO ALL STUDENTS AT ANNUAL REGISTRATION. HEALTH OFFICE: REVIEW & UPDATE INFINITE CAMPUS

ENTERED IN INFINITE CAMPUS BY: _____ DATE: _____ Revised 01/08/2016 by LAH