Kearney R-1 School District
Confidential Student Medical Information & Consent

School____________________School Year__________
Student Name__________________________________DOB____________Grade_____Teacher_____________
Parent/Guardian____
Home Phone____________________Work Phone_____________________Cell Phone______________________

Medical Diagnosis by Physician: (Check all that apply)

☐ Asthma Last event___________ ☐ *Food Allergy ☐ EpiPen® ☐ Benadryl® ☐ Chronic Ear Infections ☐ History of Head Injury ☐ Hemophilia	☐ Allergies ☐ Heart Condition ☐ Hearing Impairment ☐ Hearing Aide(s) ☐ Bone Disease ☐ Depression ☐ Chronic Pain	☐ ADD/ ☐ ADHD ☐ Cancer___________ ☐ Seizure Disorder ☐ Migraine Headaches ☐ Diabetes ☐ Pump ☐ Pen ☐ Bowel/ Bladder Problem	☐ Visual Impairment ☐ Contacts ☐ Glasses ☐ Kidney Problems ☐ Gastrointestinal Disorder ☐ Emotional Disorder ☐ Surgery ☐ Other________________

Pertinent medical information that might affect your child's day while at school

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Allergies to *food or medication(s)

____

Current medication(s) and reason for taking

____
____

Physician	Phone	Last seen
Specialist	Phone	Last seen
Dentist	Phone	Last seen

Preferred Hospital____

I give permission for the above information to be shared in confidence with appropriate staff and emergency personnel. In the event of an emergency, I authorize school personnel to obtain emergency medical care and/or emergency transportation by ambulance to the above named hospital.

Parent Signature____***Date***______________________

** If your child has a disability, or medical condition, including food allergies that require a special diet, you must submit a <u>Medical Statement for Student Requiring Special Meals</u> form. Form must be completed by your physician for the omission and/or substitution of any food(s).*