

KEOTA STUDENT HEALTH INFORMATION & PERMISSION FORM

Student Name _____ Grade _____

Is your child currently under a doctor's care? Yes ___ No ___ If yes, will medication need to be taken at school? Yes ___ No ___ Please list _____

(A doctor's prescription is required for daily administration of medication at school: ex. Inhaler for asthma or Ritalin)

Does your child have allergies? Yes ___ No ___ List _____
_____ Epi-pen required? Yes ___ No ___

Does your child have a known hearing loss? Yes ___ No ___ right, left, or both? _____

Hearing device? Yes ___ No ___ Type _____ Tubes? _____ right left or both _____

Does your child wear glasses/contacts? _____ For reading, distance or both? _____

Does your child have doctors restrictions for P.E. Or other activities? _____

Does your child have doctor-ordered diet restriction? _____

Does your child have a medical condition requiring assistance? Type of help _____

Please circle if your child has been to the dentist, medical or eye doctor this past year.

Please circle the insurance coverage your child has: medical, dental, vision.

Please circle type of insurance: Private Insurance Hawk-I Title 19 Dental

Circle below any that apply to your child:

ADHA/ADD	Bowel/Stomach problems	Diabetes	Encopresis
Headaches/Migraines	Emotional Disorder	Cancer	Depression
Fainting spells	Broken bones	Asthma	Bed wetting
Bone/muscle disorder	Positive TB test	Seizures	
Urinary/Kidney problems	Speech/Oral problem	Heart Problems	
Premature birth	Skin Condition/warts	Bleeding disorder	
Other _____			

Health History: Has your child had (please include date with explanation)

Serious illness: _____

Serious accident/injury/concussion: _____

Operation/surgery: _____

Communicable disease: (give age or date) Chickenpox _____

Mononucleosis _____ Pneumonia _____ Meningitis _____

Rheumatic Fever _____ Hepatitis _____ Measles _____

Strep Throat _____ Fifth's _____ Tuberculosis _____

The Keota School will be offering a weekly fluoride rinse program in cooperation with the Iowa State Board of Dental Health for grades 1-6.

___ Yes, I desire my child to participate in the weekly fluoride mouth rinse program.

___ No, I do not want my child to participate in the weekly fluoride mouth rinse program.

Do we have permission to give your child Tylenol or Ibuprofen according to age & weight for headaches or fever? Yes ___ No ___ (Circle medication and condition, parents will be notified for fever)

May we share your child's health information with school personnel? Yes ___ No ___

Parent signature: _____ Date: _____

