Keya Paha County School

PO Box 219 Springview, NE 68778

HEALTH INFORMATION

Student's Name: _____ Grade: _____

Permission for Non-Aspirin (Acetaminophen) or Ibuprofen;

☐ Acetaminophen (Non-Aspirin) or Ibuprofen, at a dose appropriate for my child's weight and age, may be given up to 2 times per School day if my child complains of mild headache or other minor discomfort. It is not necessary to call a parent before providing it.

☐ If my child complains of mild headache or other minor discomfort, I wish to be notified and I will make a decision about Acetaminophen or Ibuprofen provision at that time.

Acetaminophen or Ibuprofen will be given by the school nurse or a staff member trained in medication provision. Be assured that if your child is complaining of pain on an ongoing basis, if fever is > 100 degrees, or if the child is suspected of being ill, the parent will be notified. In addition, if your child is requesting one of these medications often, the parent will be asked to supply the medication.

_____ _____
Parent's signature Date

Parent home phone: _____ Parent daytime phone: _____

Please check if student has the following:

☐ Asthma ☐ Diabetes ☐ Seizure disorder ☐ SEVERE allergies

☐ Other, please explain: _____

Reminder:
If your child is entering Kindergarten or is an out-of-state transfer, a physical exam and vision exam is required.

If your child is entering 7"grade, a physical exam is required.

STUDENT HEALTH QUESTIONNAIRE
KEYA PAHA COUNTY SCHOOLS

Student Name: _____ Parents' Names: _____

Student's Birth Date: _____ Address: _____

Student's Grade: _____ Phone: _____(home) _____(Work)

Does your child suffer any of the following chronic illnesses? If so please explain in the space provided:

Diabetes ☐ Yes ☐ No If yes, indicate the type/amount of insulin taken

_____

Astluma ☐ Yes ☐ No If yes, what triggers symptoms?

_____

Epilepsy/Seizures ☐ Yes ☐ No If yes, are there any indicative symptoms?

_____

Migraine Headaches ☐ Yes ☐ No If yes, are there any signs of oncoming pain?

_____

Other Chronic Conditions ☐ Yes ☐ No If yes, please explain.

_____

Does your child suffer from allergies of any kind? If so, please indicate what your child is allergic to and explain type of reaction/symptoms:

Insect Stings ☐ Yes ☐ No Hay fever/seasonal ☐ Yes ☐ No Peanuts ☐ Yes ☐ No

_____ _____ _____

Latex ☐ Yes ☐ No Strawberries ☐ Yes ☐ No Other ☐ Yes ☐ No

_____ _____ _____

Does your child carry injectable epinephrine for any allergiés? ☐ Yes ☐ No
Does your child carry an inhaler for any allergies? ☐ Yes ☐ No
Please list any other medications taken by your child:

_____

Do any of these medications need to be taken at school? ☐ Yes ☐ No
Please note that a medication form must be filled out and returned to school for each medication taken at school, whether it is carried by the student or given by school staff.

Do you have any other specific health concerns about your child? ☐ Yes ☐ No
Have there been any major changes in the family situation in the last year such as moving, divorce, loss of someone close, or serious illness? ☐ Yes ☐ No

Name of child's physician: _____ Office phone number: _____

Name of child's dentist: _____ Office phone number: _____

I understand that the above health information is considered confidential. I authorize the school nurse and superintendent to release above information to staff members involved with my student.

Parent/Guardian Signature: _____ Date: _____