Health Information

Student's Name _____

Health Care Provider _____ Provider's Phone Number _____

Emergency Contact Information – Please list emergency contacts other than Parent/Guardian

Contact 1 _____ Relation _____ Daytime Phone _____ Cell Phone _____	Contact 2 _____ Relation _____ Daytime Phone _____ Cell Phone _____
Contact 3 _____ Relation _____ Daytime Phone _____ Cell Phone _____	Child Care Provider _____ Address _____ Home Phone _____ Cell Phone _____

Health Concerns
Parents/Guardians are responsible for providing full details on any medical condition noted to the school nurse

Please check any existing health conditions and explain below.

- ☐ Allergies
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Bowel/ Bladder
- ☐ Diabetes
- ☐ Migraines
- ☐ Emotional/Behavioral
- ☐ Heart
- ☐ Speech Concerns
- ☐ Seizures
- ☐ Frequent Infection
- ☐ Bone Joint Disease
- ☐ Headaches
- ☐ Other _____

_____

_____

Does your child have:

- ☐ Glasses or Contacts
- ☐ Other Vision concerns _____
- ☐ Hearing Aids
- ☐ Other Hearing concerns _____
- ☐ Counseling
- ☐ Prosthesis or Physical Aids (List)

_____

- ☐ Other _____

_____

Medication Information

Is your child taking any medications regularly? Yes No If yes, please list:_____

Student Medication Request Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours. Refer to Student Policy Handbook

In order for your child to attend school, immunization documentation needs to be submitted to the school office by the first day of attendance. If immunization record is not complete, the student MUST see the school nurse or designee before enrollment can be completed.

Insurance Information

Student Name_____ Student's Insurance Company*_____
(*required for extracurricular activity participation)

Is the child covered under Medicaid? Yes No **If 'yes,' please enter Medicaid ID# and Soc Sec # and sign below.**

MEDICAID # _____ Social Security #_____

Birth Date _____

As parent/guardian of the child named above, I give the school district permission to release information related to health services he/she has received at school to local, state and /or federal MEDICAID representatives for the sole purpose of allowing the school district to seek reimbursement from MEDICAID for those health services.

Signature _____ **Date _____**
(Signature of parent or person in parental relationship) **(month day year)**

If at some time you wish to withdraw permission, please contact the school building nurse

School District 27J encourages you to evaluate your own health and disability insurance to determine if you have adequate coverage for any injuries your child might sustain while at school or participating in school activities. PLEASE BE ADVISED THAT SCHOOL DISTRICT 27J DOES NOT CARRY INSURANCE FOR YOUR CHILD ON YOUR BEHALF. The district may have no liability or only limited liability for injuries that occur at school or during school activities, pursuant the Colorado Governmental Immunity Act. Voluntary Student Accident Insurance is available to all K-12 students. Application forms are distributed through the main office in each building.

SCHOOL INSURANCE OPTION

□ I want the student accident insurance and have completed the necessary form
□ I'd like to take the form home and read it before I decide
□ I do not want the student accident insurance at this time □ Form received in office