KBA

Kellman Brown Academy
Emergency Form 2017-2018 PLEASE COMPLETE & RETURN ASAP

Family Name: _____

Parent "A" (Primary contact)_____ Parent "B" Name _____

Parent "A" Home _____ Parent "B" Home _____

Parent "A" Cell _____ Parent "B" Cell _____

Parent "A" Work _____ Parent "B" Work _____

Child(ren) (last name if different) _____ Grade ___

_____ Grade ___

_____ Grade ___

_____ Grade ___

In case of an emergency and we cannot reach you, please list 3 other emergency contacts:

Name _____ Work Phone Number _____
Phone Number _____ Cell Phone Number _____
Relationship _____

Name _____ Work Phone Number _____
Phone Number _____ Cell Phone Number _____
Relationship _____

Name _____ Work Phone Number _____
Phone Number _____ Cell Phone Number _____
Relationship _____

If there is anything you would like to share with your child's/children's teacher(s), please use the space below (example: allergies, change in family situation, etc.)

_____

_____

_____

_____

This form needs to be completed and returned to Kellman Brown Academy PRIOR to the start of school on Wednesday, September 6, 2017.

Parent Signature:_____ Date:_____

PRIVATE PHYSICIAN'S EXAMINATION REPORT

Student's Name_____ DOB_____

Examining Physician_____
(Print)

Date of Exam_____ Physician's Phone Number_____

Height_____ Weight_____ Blood Pressure_____

Scalp, Head, Neck_____

Eyes_____ Last Eye Exam_____

Ears_____ Last Hearing Exam_____

Nose_____

Mouth and Throat_____

Chest and Lungs_____

Heart_____

Abdomen, Hernia_____

Genitals_____

Extremities_____

Skin_____

Posture, Gait, Spine_____

Coordination_____

Blood Pressure_____

Restrictions_____

Referral Needed YES_____ NO_____

Immunizations_____ ***Please attach shot record***

**6th grade students: Meningococcal vaccine Date_____

Tdap Date_____

Physician's Signature _____

MEDICAL PERMISSION
for
SCHOOL HEALTH SERVICES

Child's Name_____Grade _____

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. Height and weight
2. Vision screening
3. Hearing screening
4. Scoliosis screening in 5th and 7th grades
5. Blood Pressure Screening

I also give permission for my child's medical information to be shared with the appropriate teachers if necessary for his/her safety and well-being.

_____ _____

Parent's Signature **Date**

This Medical Permission Form allows your child to participate in the School Health Program. It will cover your child through the 8th grade. It will be incorporated into your child's health records.

You will still be notified before the scoliosis screening and may withdraw permission for any procedure, at any time.

Student Health Inventory

Teacher_____ Grade_____ School_____

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the School Nurse.

Name_____ Birthdate_____ Boy ☐ Girl ☐
Last First Middle

Parent/Guardian_____ Phone #_____

Parent's employment_____ _____
Father Phone Mother Phone

Emergency Contacts_____
(Other than parent) Name Phone Name Phone

Last School attended_____
Name City State

Doctor's name_____ Date of last physical _____

Dentist's name_____ Date of last exam_____

Is student under an orthodontist's care? Yes ☐ No ☐ Doctor's name_____

Does student have:

Allergies? Yes ☐ No ☐ To drugs, food, insects, pollen? Please list_____
Has the allergy required emergency action in the past? Yes ☐ No ☐
Comments_____

Bee sting allergy? Yes ☐ No ☐ Describe reaction_____
Difficult breathing? Yes ☐ No ☐ Need emergency medication? Yes ☐ No ☐

Asthma? Yes ☐ No ☐ Triggered by_____ Treatment_____
Diagnosed by doctor_____ Date_____

Diabetes? Yes ☐ No ☐ Takes insulin? Yes ☐ No ☐ Date Diagnosed_____
Epilepsy/Seizures Yes ☐ No ☐ Describe seizure_____
Date of last seizure_____ Medication_____
Is student currently under a doctor's care for seizures? Yes ☐ No ☐

Heart condition? Yes ☐ No ☐ Describe _____
Any physical restrictions?_____ Medication? Yes ☐ No ☐

Bone or joint problems? Yes ☐ No ☐ Describe _____
Any physical restrictions? _____

Check off the following regarding health concerns that pertain to student:

Eyes: ☐ Glasses ☐ Reading ☐ Distance ☐ Contacts ☐ Crossed ☐ Difficulty seeing ☐ Lazy Eye

Ears: ☐ Frequent Infections ☐ Tubes ☐ Hearing difficulty, explain

Hearing Aid ☐ Right ☐ Left ☐ Wear at School ☐ Other

Other: ☐ nosebleeds ☐ lungs ☐ eating ☐ neurologic ☐ sleeping ☐ headaches ☐ bladder ☐ bowel ☐ skin ☐ dental ☐ phobias ☐ ADD/ADHD ☐ bedwetting

Daily medication at home? Yes ☐ No ☐ At school? Yes ☐ No ☐ Emergency only? Yes ☐ No ☐
Name of medication and reason for taking_____
List serious illness or injuries_____
Surgeries (*operations*)_____ Condition that prevents PE participation_____
Other health information or concerns_____