

**KENAI PENINSULA BOROUGH SCHOOL DISTRICT**  
**Student Health Review**

STUDENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ GRADE \_\_\_\_\_  
SCHOOL \_\_\_\_\_

**For ADDITIONAL COMMENTS please use the back of the form.**

1. **LAST PHYSICAL EXAM:** Date \_\_\_\_\_ Doctor \_\_\_\_\_ Clinic Name/Location \_\_\_\_\_

2. **LAST DENTAL EXAM:** Date \_\_\_\_\_ Doctor \_\_\_\_\_ Clinic Name/Location \_\_\_\_\_

3. **LAST VISION EXAM:** Date \_\_\_\_\_ Doctor \_\_\_\_\_ Clinic Name/Location \_\_\_\_\_

4. **CURRENT MEDICATIONS** Medication(s) to be taken at School \_\_\_\_\_ (Additional form required.)  
Medication(s) taken at Home (include non-prescriptive medications taken on a regular basis) \_\_\_\_\_

5. **LAST SCHOOL ATTENDED:** \_\_\_\_\_ **PERMISSION FOR EMERGENCY CARE**  YES  NO

6. **ALLERGIES:**  NO  YES – if yes, please list specific allergies below. Use the back of the form as needed.

MEDICATION(S) \_\_\_\_\_  
What happens if your child takes this? \_\_\_\_\_  
How do you treat? \_\_\_\_\_

BEES, INSECTS, SPIDERS, etc. \_\_\_\_\_  
What happens if your child is stung or bitten? \_\_\_\_\_  
How do you treat? \_\_\_\_\_

FOOD and/or DRINK\* \_\_\_\_\_  
What happens if your child eats this? \_\_\_\_\_  
How do you treat? \_\_\_\_\_ \*School Lunch substitutions require a doctor's request.

ANIMALS \_\_\_\_\_  
What happens if your child comes in contact with this animal? \_\_\_\_\_  
How do you treat? \_\_\_\_\_

OTHER (please list) \_\_\_\_\_  
What happens if your child comes in contact with this? \_\_\_\_\_  
How do you treat? \_\_\_\_\_

7. **CURRENT MEDICAL INFORMATION:** Mark any ongoing conditions and concerns.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> asthma*                                    | <input type="checkbox"/> frequent headaches                 | <input type="checkbox"/> vision concerns         | <input type="checkbox"/> knee, back, bone or joint concerns |
| <input type="checkbox"/> other respiratory concerns                 | <input type="checkbox"/> frequent nosebleeds                | <input type="checkbox"/> wears glasses/contacts  | <input type="checkbox"/> muscular concerns                  |
| <input type="checkbox"/> diabetes                                   | <input type="checkbox"/> frequent stomachaches              | <input type="checkbox"/> dental pain or concerns | <input type="checkbox"/> mental/emotional concerns          |
| <input type="checkbox"/> heart disease                              | <input type="checkbox"/> frequently complains of being sick | <input type="checkbox"/> speech concerns         | <input type="checkbox"/> skin concerns                      |
| <input type="checkbox"/> seizures                                   | <input type="checkbox"/> ear/hearing concerns               | <input type="checkbox"/> urinary/bowel concerns  | <input type="checkbox"/> other _____                        |
| <input type="checkbox"/> previous head injury with unconsciousness* | <input type="checkbox"/> tubes in place                     |  |   |

\*additional forms may be requested  
For **COMMENTS** use the form back.

**CURRENT SPECIFIC MEDICAL DIAGNOSIS:**  NO  YES

Diagnosis \_\_\_\_\_ Doctor \_\_\_\_\_ Clinic Name/Location \_\_\_\_\_  
Date Identified \_\_\_\_\_ Care/treatment required at school \_\_\_\_\_

**CURRENT PHYSICAL ACTIVITY LIMITATIONS** \_\_\_\_\_

8. **PAST MEDICAL INFORMATION: Operations, injuries, hospitalizations, and past medical concerns, including birth information and history of developmental delays as appropriate (please include dates):** \_\_\_\_\_

9. **ADDITIONAL INFORMATION:** Please add any additional information helpful to the school staff (i.e., family, learning, special needs)

**My signature allows for information that pertains to school safety or helps my child in the classroom to be shared with additional school staff as appropriate.**

**PERSON COMPLETING THIS FORM:** \_\_\_\_\_  
(Name) (Relation to child) (Today's Date)