NAZARETH AREA SCHOOL DISTRICT KINDERGARTEN HEALTH INFORMATION FORM

Completed at kindergarten registration then followed up yearly with the health update form sent to every student at the beginning of the school year

If your child receives any immunizations or has a change in their health history after kindergarten registration, please contact the school nurse.

Name of Child:		**Date of Birth:**	
Grade:	Kindergarten	**School:**	**KNBES**

Hearing Impairment: ☐ yes ☐ no **Describe:** ____________________

Speech Difficulties: ☐ yes ☐ no **Describe:** ____________________

Vision Impairment: ☐ yes ☐ no **Describe:** ____________________

Had Chicken Pox Disease: ☐ yes ☐ no (If yes, age or year of disease) __________

Health Concerns and/or Illnesses ***Current or Past***

- ☐ Asthma
- ☐ ADHD
- ☐ Cancer
- ☐ Orthopedic Concern
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Heart Concerns
- ☐ Hemophilia
- ☐ Sickle Cell Disease/Trait
- ☐ Bladder/Kidney Concern
- ☐ Hepatitis
- ☐ Bowel Concern
- ☐ Migraines
- ☐ Mental Health issues
- ☐ Other: ____________

If your child has any of these concerns please explain further: ____________________

____

Diabetes ☐ Type I ☐ Type II Date diagnosed: __________

Insulin dependent: ☐ yes ☐ no Insulin Pump? ☐ yes ☐ no

Seizures Type of seizure: __________ Date of last seizure: __________

Under a doctor's care for seizures: ☐ yes ☐ no Date last seen: __________

Medication: ____

Any history of serious accident and/or injury: ☐ yes ☐ no Date of injury: __________

Treatment of Injury: ______________________________

Hospitalization/Surgery (date and reason): ______________________________

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Special Diet: ____

Allergic to: ☐ Bees ☐ Peanuts ☐ Eggs ☐ Milk ☐ Tree nuts ☐ Latex

☐ Other **please explain:** ______________________________________

Reaction: ☐ Localized ☐ Systemic ☐ Anaphylactic

Medication needed: ☐ Benadryl ☐ Epi-pen

Medication:

Is your child taking any medication regularly? ☐ yes ☐ no

Does this medication need to be taken during school hours: ☐ yes ☐ no

Name of medicine: ____

Reason for taking medicine: ______________________________________

Does your child have any **restrictions** because of his/her health? ☐ yes ☐ no

If yes, please specify restrictions: ________________________________

Please list any other concerns you want the school nurse to be aware of below:

The above information is accurate and complete to the best of my knowledge. I give permission to share information with appropriate school personnel, as necessary.

Parent/Guardian Signature: ______________________ **Date:** __________

For additional information and forms from the nurse (allergy action plan, asthma plan, seizure plan, diabetic plan, medication form, physical, dental etc.) use the QR code or go to the nurse's office link on the Kenneth N Butz Elementary School website https://www.nazarethasd.k12.pa.us/kbes under the Main Office tab.

All forms and documents can be mailed, faxed or scanned and emailed to the nurse:

Kenneth N. Butz Elementary
Attn: Christine Brown School Nurse
960 Bushkill Center Rd.
Nazareth, PA 18064
Fax: 610-849-0866
cbrown@nazarethasd.org