Notre Dame de Sion School

GS Returning Student Health History

ndsion.edu

GRADE SCHOOL | 3823 Locust Street | Kansas City, MO 64109 | 816.753.3810
HIGH SCHOOL | 10631 Wornall Road | Kansas City, MO 64114 | 816.942.3282

STUDENT INFORMATION

Student Name: ____ Gender: male female

Date of Birth: ____________________________________ Grade: M K 1 2 3 4 5 6 7 8

Parent/Guardian Name: _______________________________ Phone: ________________________ Parent/ Guardian Name: _______________________________ Phone: ________________________ Physician: ____ Phone: ________________________ Dentist: ____ Phone: __________________________

Preferred Hospital: ____

Emergency Contact: ______________________________________ Phone: __________________________

Health Conditions (check those that apply)					
ADD/ADHD		Cardiovascular (Heart/Blood Disease)		Seizures	
Allergies/Anaphylaxis		Diabetes		Visually Impaired	
Asthma		Eating Disorder		Hearing Impaired	
Behavioral/Emotional/Psychological		G.I. Disorder (Stomach/Intestinal)		Migraine Headaches	

Please fully explain any answers checked above (include severity of symptoms of any allergies)

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Please list any medication the students takes on a regular basis

____

Please list any physical education restrictions if applicable

____

Please list any other factors that the school, counselor, or your child's teacher(s) should know that might affect the student's school experience

____

I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

____ ________________

Parent/Guardian Signature Date

I authorize school personnel to administer over the counter medications.

____ ________________

Parent/Guardian Signature Date

Please initial one below:

_______This health information is confidential and is not to be shared with anyone outside the health room unless needed for emergency reasons.

_______I feel it is important to share health information with the teaching staff as appropriate.

PLEASE ATTACH A PHYSICIAN'S RECORD OF ANY IMMUNIZATIONS RECEIVED WITHIN THE PAST YEAR