KIRKWOOD
SCHOOL DISTRICT

Annual Medical Information Form

Enrollment for School Year:
☐ 2015-16 ☐ 2016-17 ☐ 2017-18 ☐ 2018-19 ☐ 2019-20

**** To Be Completed By Parent Or Guardian ****

Student's Name: _____ **Nickname:** _____
(Last Name, First, Middle Initial)

Gender: ☐ Male ☐ Female **Date of Birth:** ____/____/____ **Grade:** _____

School: *(Circle One)* KECC KHS Keysor N Glendale Nipher NKMS Robinson Tillman Westchester

Please place an "x" or check mark in the answers preceeded by "Yes" or "No". Please include names of medications.

YES	NO		YES	NO	
☐	☐	**ADD/ADHD** Medication: _____	☐	☐	**Stomach/Bowel Problems** Medication: _____
☐	☐	**Anxiety** Medication: _____	☐	☐	**Heart/Lung Problems** Medication: _____
☐	☐	**Autism/Asperger's** Medication: _____	☐	☐	**Kidney/Bladder Problem** Medication: _____
☐	☐	**Asthma** Medication: _____ (Please attach updated asthma action plan)	☐	☐	**Seizures** Medication: _____ (Please attach updated seizure action plan)
☐	☐	**Food Allergies** (peanuts, tree nuts, eggs, milk, food dye, etc.) Specify: _____ Medication: _____ (Please attach updated food allergy action plan)	☐	☐	**Hearing Concerns** Appliances: _____
			☐	☐	**Vision Concerns** (glasses, contacts) Last Eye Exam: _____
☐	☐	**Dietary Restrictions** Specify: _____	☐	☐	**Surgical History** Specify: _____
☐	☐	**Allergies** (seasonal, animal dander, sting, etc.) Specify: _____ Medication: _____	☐	☐	**Orthopedic Issues** (assistive devices)
☐	☐	**Diabetes** Medication: _____ (Please attach updated diabetes action plan)	☐	☐	**Headaches/Migraines** Specify: _____
			☐	☐	**History of Concussion** When?: _____
☐	☐	**Depression/Mental/Behavioral/Emotional Illness** Specify: _____ Medication: _____	☐	☐	**History of Cancer** Specify: _____
☐	☐	**Sickle Cell** Medication: _____	☐	☐	**Cranial Shunt**
☐		**Other Health Concerns/Injuries** Specify: _____			

Other than what is listed above, is your child currently taking any medication on a regular basis? (Prescription or over the counter)

Medication: _____ Reason: _____ Dose: _____ Times(s)
Medication: _____ Reason: _____ Dose: _____ Times(s)
Medication: _____ Reason: _____ Dose: _____ Times(s)
Medication: _____ Reason: _____ Dose: _____ Times(s)

Doctor: _____ Phone: _____

Doctor: _____ Phone: _____

Hospital Preference: _____ Phone: _____

SCHOOL ILLNESS POLICY *PLEASE INITIAL*

_____ I am aware that the District Policy on ill children states that students are to go home and remain home for vomiting, diarrhea, and fevers over 100.0F for 24 hours without medication.

Parent's Signature: _____ **Date:** _____

OFFICE USE ONLY: DATE REC'D:

16-01-05 ASC LD