Keystone Montessori School
Student Health Information

SCHOOL: _____ **SCHOOL YEAR:** _____

STUDENT INFORMATION *(Please give student's complete legal name)*

Last Name	First Name	Middle Name	Homeroom Teacher

Student's Social Security #	Student's Birth Date	Sex F M	Is the student Hispanic/Latino? Yes No

Race-Required (check **one or more**): American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White

Street Address	Apt	City	Zip

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION

Guardian 1 Name	Relationship to Student	Home Phone	Work Phone	Cell Phone
Guardian 2 Name	Relationship to Student	Home Phone	Work Phone	Cell Phone
Emergency Contact (Other than Guardian)	Relationship to Student	Home Phone	Work Phone	Cell Phone

STUDENT'S Medical Insurance

Does your student have a KY Medicaid or K-CHIP Card? Yes No Number _____

Does your student have other medical insurance? Yes No Name of Company_____

STUDENT'S Medical History

1) Significant Medical History: _____
2) Medication Allergies: _____ Food Allergies: _____
3) Other Allergies: _____
4) Medications taken Daily: _____
5) * Prescription Medication to be given at School: _____

Student's Health Care Provider: _____ Phone: _____

**Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

Does your student have any of the following life-threatening conditions that may require EMERGENCY treatment or medications to be given at school?

DIABETES (Glucagon)	ASTHMA (Rescue Inhaler)	SEIZURES (Diastat)	LIFE-THREATENING ALLERGY (Epi-Pen)	OTHER: _____

CONSENT FOR HEALTH SERVICES

All students will receive basic First Aid and emergency care. By signing this form, I consent to Health Services given to my student while at school. I authorize Keystone Montessori Schools to release medical information about my student to his/her Primary Care Provider. **EXPIRES ONE YEAR AFTER DATE SIGNED.**

X_____ ____ /____ /_____

(Signature of Parent / Legal Guardian / Emancipated Student) *(Date signed)*

THIS SECTION FOR SCHOOL USE ONLY

Care Plan(s) Sent	Date: _____	Date: _____	Care Plan(s) Returned Date: _____	Date: _____

Please Return Completed Form To School