## Keystone Montessori School Student Health Information

| List Name  | SCHOOL:  | SCHOOL: SCHOOL YEAR:                      |            |                         |                            |            |            |                |  |
|--|--|---|------------|-------------------------|----------------------------|------------|------------|----------------|--|
| Student's Social Security # Student's Birth Date   Sex   Is the student Hispanic/Latino?    Race-Required (check one or more):   American Indian or Alaska Native   Asian   Black or African American   Native Hawaiian or Other Pacific Islander   White  |  |   |            |                         |                            |            |            |                |  |
| Race-Required (check one or more):   | Last Name  |   | First Name | M                       | ddle Name Homeroom Teacher |            |            | neroom Teacher |  |
| 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    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    2)   Medication Allergies:   Food Allergies:   3) Other Allergies:   Food 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   ASTHMA   SSIZURES   LIFE-THREATENING   OTHER:    (Glucagon)   (Rescue Inhaler)   (Diastat)   LIFE-THREATENING   OTHER:    (Glucagon)   (Rescue Inhaler)   (Diastat)   LIFE-THREATENING   OTHER:    (Glucagon)   (Rescue Inhaler)   (Diastat)   Stigning this form, I consent to Health Services given to my student while at school.   authorize Keystone Montessori Schools to release medical information about my student to his/her Primary Care Provider.   EXPIRES ONE YEAR AFTER DATE SIGNED.    **THIS SCHOON FOR SCHOOL USE ONLY   (Date signed)    THIS SCHOON FOR SCHOOL USE ONLY   (Date signed)    **THIS SCHOON FOR SCHOOL USE ONLY   (Date signed)    **THIS SCHOOL USE ONLY   (Date Plan(s) Returned   (Date Plan(s) Returned   (Date Plan(s) Returned   (Date Plan(s) Plan(s) Returned   (Date Plan(s) Plan(s) Plan(s)   (Date Plan | Student's Social S   | nt's Social Security # Student's Birth Da |            |                         |                            | •          |            |                |  |
| 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 Medicald or K-CHIP Card? Yes No Number   | Race-Required (check one or more):   |   |            |                         |                            |            |            |                |  |
| Guardian 1 Name  Relationship to Student Home Phone Work Phone Cell Phone  Bemergency 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: 3) Other Allergies: 4) Medications taken Daily: 5) ** Prescription Medication to be given at School: Student's Health Care Provider: **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 ASTHMA SEIZURES (Diastat) ALLERGY (Epi-Pen)  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)  THIS SECTION FOR SCHOOL USE ONLY  Care Plan(s) Date: Date:  Care Plan(s) Date: Date: Care Plan(s) Date: Date: Care Plan(s) Date: Date: Care Plan(s) Date: Ca | Street Address   |   |            |                         | Apt                        | City       |            | Zip            |  |
| Guardian 1 Name  Relationship to Student Home Phone Work Phone Cell Phone  Bemergency 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: 3) Other Allergies: 4) Medications taken Daily: 5) ** Prescription Medication to be given at School: Student's Health Care Provider: **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 ASTHMA SEIZURES (Diastat) ALLERGY (Epi-Pen)  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)  THIS SECTION FOR SCHOOL USE ONLY  Care Plan(s) Date: Date:  Care Plan(s) Date: Date: Care Plan(s) Date: Date: Care Plan(s) Date: Date: Care Plan(s) Date: Ca | PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION  |   |            |                         |                            |            |            |                |  |
| Emergency Contact (Other than Guardian)  Relationship to Student  STUDENT'S Medical Insurance  Does your student have a KY Medicaid or K-CHIP Card?  | -  |   |            |                         | nt                         | Home Phone | Work Phone | Cell Phone     |  |
| STUDENT'S Medical Insurance  | Guardian 2 Name  |   |            | Relationship to Student |                            | Home Phone | Work Phone | Cell Phone     |  |
| Does your student have a KY Medicaid or K-CHIP Card? Yes No Number   | Emergency Contact (Other than Guardian)  |   |            | Relationship to Student |                            | Home Phone | Work Phone | Cell Phone     |  |
| Does your student have a KY Medicaid or K-CHIP Card? Yes No Number   | STUDENT'S Medical Insurance  |   |            |                         |                            |            |            |                |  |
| STUDENT'S Medical History  1) Significant Medical History:   | Does your student have a KY Medicaid or K-CHIP Card? Yes No Number                       |   |            |                         |                            |            |            |                |  |
| 1) Significant Medical History:  | Does your student have other medical insurance? Yes No Name of Company                   |   |            |                         |                            |            |            |                |  |
| 2) Medication Allergies:   | STUDENT'S Medical History  |   |            |                         |                            |            |            |                |  |
| 3) Other Allergies:  | 1) Significant Medical History:  |   |            |                         |                            |            |            |                |  |
| 4) Medications taken Daily:  5) * Prescription Medication to be given at School:  Student's Health Care Provider:  |  |   |            |                         |                            |            |            |                |  |
| Student's Health Care Provider:  | 3) Other Allergies:  |   |            |                         |                            |            |            |                |  |
| Student's Health Care Provider:  | 4) Medications taken Daily:  |   |            |                         |                            |            |            |                |  |
| *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?   | 5) * Prescription Medication to be given 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 ASTHMA SEIZURES LIFE-THREATENING OTHER: (Glucagon) (Rescue Inhaler) (Diastat) ALLERGY (Epi-Pen)  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.  (Signature of Parent/Legal Guardian / Emancipated Student)  THIS SECTION FOR SCHOOL USE ONLY  Care Plan(s) Date: Date: Care Plan(s) Returned   | Student's Health Care Provider: Phone:   |   |            |                         |                            |            |            |                |  |
| DIABETES   ASTHMA   SEIZURES   LIFE-THREATENING   OTHER:   (Glucagon)   (Rescue Inhaler)   (Diastat)   ALLERGY (Epi-Pen)   |  |   |            |                         |                            |            |            |                |  |
| DIABETES (Glucagon) (Rescue Inhaler) (Diastat) LIFE-THREATENING ALLERGY (Epi-Pen)  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.  (Signature of Parent / Legal Guardian / Emancipated Student) (Date signed)  THIS SECTION FOR SCHOOL USE ONLY  Care Plan(s) Date: Date: Care Plan(s) Returned   | Does your student have any of the following life-threatening conditions that may require |   |            |                         |                            |            |            |                |  |
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| 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.  (Signature of Parent / Legal Guardian / Emancipated Student) (Date signed)  THIS SECTION FOR SCHOOL USE ONLY  Care Plan(s) Date: Date: Care Plan(s) Returned  |  |   |            |                         |                            |            |            |                |  |
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| THIS SECTION FOR SCHOOL USE ONLY  Care Plan(s) Date: Date: Care Plan(s) Returned   | X  |   |            |                         |                            |            | /          | /              |  |
| Care Plan(s) Date: Date: Care Plan(s) Returned   | (Signature of Parent / Legal Guardian / Emancipated Student) (Date signed)               |   |            |                         |                            |            |            |                |  |
|  |  |   |            |                         |                            |            |            |                |  |
|  | Care Plan(s) Sent  | Date:                                     |            |                         |                            |            | Date:      |                |  |