

Kane Area School District 2024-2025
Information and Authorization for School Health Services

The following information is needed in order for the school nurses to give the most effective medical attention and treatment to your child. Please complete and return this form by August 31st, 2024.

Student's Name _____ Date of Birth _____ Grade _____

Medical conditions, mental/emotional conditions, physical limitations and recent surgeries: _____

Did your child sustain any type of head injury over the summer? ☐ Yes, date _____ ☐ No

Does your child have a **severe allergy**? (Food, insect sting, medication, other) Please specify

What treatment is necessary _____

Is an **epinephrine auto injector or asthma inhaler** required during school? ☐ Yes ☐ No

List any daily medications taken; please give name, dose and frequency:

Immunizations received this year and date (please provide copy for your child's record)

In the case of an extreme emergency, and we are unable to contact you, your child will be transported to the nearest hospital. Please list your family physician.

Physician _____ Phone _____

Does your child have medical insurance/ hospitalization coverage ☐ Yes ☐ No

I give my permission to make the information on this form available to authorized school and transportation personnel if necessary. I also give permission to my child's health care provider/dentist to share any necessary information relating to my child's health with the school nurse.

Signature _____ Date _____