Katy Independent School District

PERMANENT HEALTH RECORD INVENTORY

If your child has an acute or chronic medical condition, or any changes occur during the school year, be certain to contact your school nurse.

In an effort to provide safe, informed care for your child at school, the KISD Health Services Department requires the following information to complete your child's enrollment. Medical information you provide about your child is a confidential education record. KISD keeps all medical information about your child confidential as required by law. However, health information about your child may be communicated to KISD school personnel who have a direct "need to know" for the health and safety of your child.

Student Name: (Last) (First) (Middle)		
Date of Birth:	Gender: ☐ Male ☐ Female	
Grade:	Home Phone:	
Parent Name:	Cell:	WK:
Parent email:		

Has anyone residing in your household been in another country within the last 21 days? ☐ **YES** ☐ **NO**
If YES, Where?

PLEASE MARK ANY OF THE FOLLOWING THAT APPLY	
	My child has no known health conditions or allergies
	I certify that my child had chickenpox on or about (Month/Year) and does not need the Varicella (chickenpox) vaccine.

HEALTH CONDITIONS

Allergies		
To Food	To Medication	To Insects
Does your child require an Emergency Medication for an allergic reaction at school? ☐ YES ☐ NO		
If yes, list medication:		
Asthma		
List medication, time and dosage:		
Does your child use a nebulizer? ☐ YES ☐ NO		
Diabetes		
Type 1 ☐	Type 2 ☐	
Neurological (seizures, migraines, cerebral palsy)		

	Abdominal (Irritable Bowel, gastric reflux, constipation)		Heart Condition
	ADD/ADHD		Nerve/Muscle/Bone Disorder
	Blood Disorders		Past surgeries/hospitalizations
	Dietary Needs/Restrictions		Respiratory (Cystic Fibrosis)
	Ear/Nose/Throat (frequent nosebleeds, ear infections, hearing loss)		Visual Disability (blindness, prosthesis, eye surgery)
	Emotional (depression/OCD)		Other (please explain)

MEDICATIONS and SPECIALIZED PROCEDURES

Please contact the school nurse if your child requires a special procedure (e.g., catheterization, tube feeding, glucose monitoring, nebulizer, etc.) A separate form is required.

Name of Medication	Dosage	Reason	At Home	At School **

Any medication needed at school must be brought to the school clinic. A separate permission form is required for each medication.
(Parent/Physician Request for Administration of Medication by School Personnel)

Parent/Guardian Signature: _____ Date: _____