CUMULATIVE HEALTH RECORD
FORT LEAVENWORTH UNIFIED SCHOOL DISTRICT 207
FORT LEAVENWORTH, KS 66027-1425
(To be completed by parent/guardian)

Child's Name _____ (M/F) Birth date _____ Age_____ Grade_____/Teacher_____
Home Address_____ Home Phone _____ Previous School_____State___
Sponsor's Name _____ Rank _____ E-Mail _____
Military Section or Unit _____ Work Phone _____ Cell Phone _____
Spouse's Name_____ Spouse's Work Phone _____ Spouse's Cell Phone _____

Local emergency contacts in case parent cannot be reached and alternate pick-up list. Include at least two.

1. _____ Phone _____ 3. _____ Phone _____
2. _____ Phone _____ 4. _____ Phone _____

Check if your child has problems in any of the following areas and explain:

Orthopedic/ Physical Limitations_____ Heart Problems/ Murmur_____
Wears Glasses/Contacts ❑ Full time ❑ Reading ❑Distance ❑ None Seizures _____
Hearing Problems/ Hearing Aids/ Tubes_____ Bladder/ Bowel Problems_____
ADD/ ADHD_____ Medication_____ Mental/ Emotional Problems_____
Speech/Speech Therapy_____ Skin Disorders_____ Diabetes_____
Allergies to: Medications_____ Allergies to: Food_____
Allergies to: Seasonal/Environmental_____ Asthma _____ Inhaler_____
History of Anaphylaxis to_____ Epipen ❑Yes ❑ No Special Health Needs/ Other _____
List any medications your child is taking: _____ When Taken _____

I grant permission for my child to receive the following while in school:

Emergency medical care Yes ____ No ____ Caladryl/Calamine Lotion Yes ____ No ____
Tylenol Yes ____ No ____ Tums/Maalox/Mylanta Yes ____ No ____
Ibuprofen Yes ____ No ____ Benadryl Yes ____ No ____
Scoliosis Screening for 5th and 6th Grade Girls and 7th, 8th, 9th Grade Boys and Girls Yes ____ No ____

***We cannot give ANY prescription medications without permission signed by a doctor and parent/guardian. Students may NOT carry medications with them in school.**

Parent's Signature _____ Date _____

For Nurse Only:

	Screening Date	Results	Follow-up Information
Vision	_____	R 20/____ L 20/____ (glasses/contacts)	Referral ❑ _____
Hearing	_____	Pass ❑ Retest ❑ Pass ❑ Fail ❑	Referral ❑ _____
Scoliosis	_____	Pass ❑ Fail ❑	Referral ❑ _____

Height _____in Weight _____lbs BMI_____ BMI%_____ Immunizations Received _____ Physicals Received _____

Parents: Use back of form to record pertinent health history that might develop this school year.

Revised 15 April 2010