Colorado Springs School District 11

Student Health Information Update

NOTE: The following information is confidential and will be shared with school staff on a need to know basis.

Student Name: _____

School: _____

Student ID: _____ Grade: _____

School Year: _____

Does your child have any of the following health problems? Birth Date: _____ mmddyyyy

- ☐ Autism spectrum
- ☐ Autoimmune problems
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Blood disease
- ☐ Bone/joint
- ☐ Bowel/bladder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Emotional concerns
- ☐ Genetic/congenital abn.
- ☐ Glasses/contacts
- ☐ Hay fever
- ☐ Head injury/concussion
- ☐ Heart condition
- ☐ Migraines
- ☐ Seizures
- ☐ Sleep disorder
- ☐ Vision concerns
- ☐ Hearing impaired
- ☐ Stomach

Comments/Concerns: _____

Allergies: Does your child have any significant allergies that school personnel should know about? ☐ Yes ☐ No

If yes, list allergy and symptoms of allergic reaction: _____

How is it treated? _____

NOTE: If your child has a food allergy, please contact the Kitchen Manager at your child's school.

Medications: Does your child take medications? ☐ Yes ☐ No If yes, what is it for? _____

Please list name of medication(s) and dosage: _____

Will this medication be given at school? ☐ Yes ☐ No

(Please note: School District 11 requires completion of the blue "Medication Form" by parent and physician for all medications given at school.)

Activity Restrictions: Has your child's doctor placed any current restrictions on your child's physical activities? ☐ Yes ☐ No

If yes, please describe and provide written documentation from your physician. _____

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Health Insurance: Insurance Company: _____ Medicaid #: _____ CHP+ _____

If no insurance at this time, would you like to be contacted regarding health coverage? ☐ Yes ☐ No

Consent for Medicaid Billing: I give consent to and authorize Colorado Springs School District 11 to release to Colorado Health Care Policy and Financing (HCPF) information related to Medicaid eligible services the District provides to the student identified above, as necessary, to apply for and recover partial Medicaid reimbursement. If at any time you would like to revoke this permission, please contact the school district Medicaid Office at 719-520-2251.

Emergency Care Permit: When a child suffers any injury or illness while at school, an immediate and continuing effort will be made to contact the parents. In case of serious injury or illness, first aid will be rendered in accordance with local school policies. If ambulance service is necessary, parents must assume financial responsibility.

If I cannot be reached by telephone in the event of an emergency involving _____ (Child's name)

please send my child to _____ or any available medical service.

(Hospital preferred)

What is your daytime phone number? _____

Parent/Guardian Signature _____ **Date** _____