



KELLER INDEPENDENT SCHOOL DISTRICT  
HEALTH SERVICES

**Student**

School Year: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Last, First Name: \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Emergency Information**

Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Does your child take any medication on a regular basis? Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Medicine \_\_\_\_\_ Dosage \_\_\_\_\_

Is your child allergic to any food or drug? Please list: \_\_\_\_\_

Will you be providing an Epi-Pen? **Yes/No**

Past operations/serious injuries \_\_\_\_\_

**Please make the nurse aware of any chronic illness or health problems (diabetes, seizures, asthma, etc.)  
or anything that the nurse should know to better care for your child** \_\_\_\_\_

May the nurse share this information on a need to know basis? **Yes/No**

For children with life threatening conditions please see the school nurse for further information.

Does your child wear \_\_\_glasses, \_\_\_contacts, \_\_\_ hearing aid, or have a \_\_\_prosthesis?

Has your child had chicken pox (varicella) disease? If so, please provide date: Month \_\_\_\_\_ Year: \_\_\_\_\_

***I hereby authorize the person(s) listed as EMERGENCY CONTACTS and PHYSICIAN on this form to be notified at the school's discretion and do authorize the named doctor/emergency contact to render such treatment as may be deemed necessary in an emergency, for the health of said child. I further assume the responsibility for payment of any professional emergency services required.***

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date



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**SEIZURE HEALTH PLAN**

Student's Name: \_\_\_\_\_ School Year: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

Type of Seizure: \_\_\_\_\_

Describe Seizure (how will we recognize): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Precipitating Factors that may cause a seizure: \_\_\_\_\_

\_\_\_\_\_

Date of Last Seizure: \_\_\_\_\_

Current Medications/Dosage: \_\_\_\_\_

\_\_\_\_\_

What action should be taken when a seizure occurs :( rest, call parents, when to call  
911): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Name/Number: \_\_\_\_\_

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_



KELLER INDEPENDENT SCHOOL DISTRICT  
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ASTHMA HEALTH PLAN

STUDENT'S NAME \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_

GRADE/TEACHER \_\_\_\_\_

DOCTOR'S NAME AND NUMBER \_\_\_\_\_

Please list the medications your child takes for asthma (everyday and as needed).

Name of Medication (In School)

\_\_\_\_\_

Name of Medication (At home)

\_\_\_\_\_

What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply)

Breathing exercises

Rest/relaxation

Drink liquid

Takes Medication

Other \_\_\_\_\_

Will student require nebulizer treatments at school? \_\_\_YES \_\_\_NO (Parent must provide)

ASTHMA TRIGGERS (exercise, allergies, animals, etc.)

\_\_\_\_\_

Will student require peak flow monitoring? \_\_\_YES \_\_\_NO (Parent must provide)

Personal Best Peak Flow Number \_\_\_\_\_

Monitoring Times \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



KELLER INDEPENDENT SCHOOL DISTRICT  
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**DIAZEPAM RECTAL MEDICATION (DIASTAT) SPECIAL PROCEDURE FORM**

STUDENT'S NAME \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_

GRADE/TEACHER \_\_\_\_\_

Procedure for Administration of Diazepam Rectal Medication (Diastat):

1. Diazepam Rectal Medication (Diastat) Dosage:
2. Indications for treatment (be very specific) including length of time seizure should last before treatment begins:
3. Side effects expected after the administration of medication:
4. Action to be taken if child has bowel movement or expels medication:
5. Should medication be given if child has fever, respiratory infection or cold:
6. Protocol is to call 911 after administering Diazepam Rectal Medication (Diastat) unless specifically ordered otherwise (and always after initial dose of this drug).

**Please explain in detail any circumstances where it is not necessary to call 911:**

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7. **Please note:** If prolonged seizure occurs at any time when a nurse is not available, 911 will be called.

Printed name of physician: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Date of Termination: \_\_\_\_\_

I request that Diazepam Rectal Medication (Diastat) be administered to my child according to the signed protocol from my physician.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Gastrostomy Health Plan**

Student's Name: \_\_\_\_\_ School Year: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

Type of G-Tube/Button: \_\_\_\_\_

\_\_\_\_\_

Instructions for Feeding:

1) Formula: \_\_\_\_\_

2) Amount: \_\_\_\_\_

3) Method of administration: \_\_\_\_\_

Equipment needed (Supplied by parent): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4) Flushed with \_\_\_\_\_cc water

5) Duration of feeding: \_\_\_\_\_

6) Student position: \_\_\_\_\_

7) Cleaning method: \_\_\_\_\_

If tube/button becomes dislodged, what treatment should be taken (i.e. cover with gauze, call parent, call 911)? Is there a time frame for replacement?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other pertinent information?

\_\_\_\_\_

\_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



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**ALLERGIC REACTION HEALTH PLAN**

STUDENT'S NAME \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_

GRADE/TEACHER \_\_\_\_\_

**\*ALLERGIC TO** \_\_\_\_\_  
ASTHMATIC \_\_\_ YES \_\_\_ NO

**\*WHAT SIGNS ARE PRESENT FOR A MINOR REACTION?**  
(I.E; ITCHING, HIVES, SWELLING) \_\_\_\_\_  
\_\_\_\_\_

What action should be taken? \_\_\_\_\_  
\_\_\_\_\_

**\*WHAT SIGNS ARE PRESENT FOR A MAJOR REACTION?** \_\_\_\_\_  
\_\_\_\_\_

What action should be taken?  
(CALL 911, ADMINISTER MED, CALL PHYSICIAN)  
\_\_\_\_\_

Will you be providing medication? Yes/No (If yes, a separate form is required)

Will you be providing an Epi-Pen? Yes/ No (If yes, a separate form is required)

Doctor's Name/Number \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



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**PHYSICIAN/PARENT REQUEST  
FOR ADMINISTRATION OF SPECIAL PROCEDURE**

The prescribed in-school procedure may be administered by the school nurse and/or non-health care professional as prescribed by the physician. Due to the unavailability of school nurses on each campus daily, a non-health care employee may be designated to perform the procedure. Any special health care /nursing procedures that need attention during school hours will be administered upon receipt of this completed form, along with any special equipment needs.

Name of Student	DOB	
Address	City	Zip
School Name	Grade/Teacher	

1. Condition for which prescribed treatment is required: \_\_\_\_\_
2. Specific procedure: \_\_\_\_\_
3. Method of administration: \_\_\_\_\_  
\_\_\_\_\_
4. Precautions, unfavorable reactions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Disposition of student following procedure, if applicable, i.e. rest, home, class, doctor, etc.:  
\_\_\_\_\_  
\_\_\_\_\_

Date of Request	Date of Termination
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Physician's Name	Physician's Signature
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Physician's Address	Physician's Phone Number
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We (I), the undersigned, the parents/guardians of \_\_\_\_\_  
approve the above procedure to be administered to our (my) child by KISD personnel.

Parent Name	Parent Phone Number
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