Westfield Washington School District

Student Health History Form

This form is due the first day each school year

2016-17

Student's Name_______________________

Birth date:____/____/____ Male_____ Female______

School:______________________________ Grade:________

The following information is **Confidential**. Parents/Guardians are required to complete **a new form each school year** or if new medical information needs updated.

PERMISSION TO GIVE NON-PRESCRIPTION MEDICATION AT SCHOOL

☐ **Yes** ☐ **No** My child may receive school provided over the counter medication(s) in my absence from the school health clinic (dosed according to the medication label by age/weight)

Comments:____

____

Medications provided in the clinic are: Acetaminophen (Tylenol), Ibuprofen, Antacids, Diphenhydramine (Benadryl), Topicals (Hydrogen peroxide, antibiotic ointment, hydrocortisone, anti-itch cream, Vaseline, carmex/blistex, hand/body lotion, Caladryl/calamine lotion, sting kill, sunburn relief lotion (may contain aloe and/or lidocaine)

GRADES K, 6 and 12: VACCINE RECORDS WITH ADDITIONAL VACCINES ARE REQUIRED

Students entering grades K, 6 and 12 are required to have additional vaccines and must submit a copy of their updated vaccine records with these additional vaccines to the school nurse prior to the first day in order to attend school. Objections and exemptions must be resubmitted every school year. Contact your physician or the school nurse if you have any questions. * See the district website wws.k12.in.us "Parents", "Health Services", School Required Immunizations" for required vaccines by grade level.

Kindergarten students- a physical exam is highly recommended before starting school. Please provide a copy of the exam and your child's immunization record to your school nurse along with this form.

ALLERGIES

Does your child have any significant allergies? (Include known food allergies) ☐**Yes** ☐**No**

If yes, list allergy(s) and symptom(s) of allergic reaction:

How is the allergy treated? ____

Does your child have EPI PEN, EPI JR or Auvi-Q prescribed to treat the allergy? ☐Yes ☐No

(If yes, please contact your school nurse before the first day of school to prepare an emergency action plan for school)

DAILY MEDICATIONS

Does your child require medication to be given at school? ☐**Yes** ☐**No (if yes, please contact your school nurse)**

- All prescription medication to be given at school require a medical order from your child's physician for school
- **Only parents/guardians are allowed to bring medication to school. Do not send with your student.** See your student handbook for rules/regulations regarding medication at school.

Does your child take daily medications at home? ☐**Yes** ☐**No (If yes, please list the current medications)**

Name of Medication	Dose	Time given	Reason given

Don't forget to complete the back side of this form

MEDICAL HISTORY

Does your child have any of the following conditions? (Check all that apply, explain in the box below) ☐ **None**

☐ ASD (Autism)	☐ Cancer	☐ Genetic/Congenital	☐Migraines
☐ ADD/ADHD	☐ Diabetes	☐ Glasses/Contacts	☐Other
☐ Asthma	☐ Eating Disorder	☐ Heart Condition	☐Sleep disorder
☐ Blood Disease	☐ Emotional Concerns	☐ Head injury/concussion	☐Seizures
☐ Bowel/Bladder	☐ Food Allergy/Intolerance	☐ Hearing Impaired	☐Stomachache

Comments/Concerns

List any recent hospitalization or treatments and explain (please include dates):

____

____

MEDICAL PROCEDURES OR TREATMENTS REQUEST

Does your child have any special medical procedures or emergency treatments needed during school hours?

☐Yes* ☐No

*All medical procedures or treatments required at school must have a doctor medical order on file with the school nurse before any nursing procedures/treatments can be performed. Orders are good for 1 school year; please contact your school nurse for assistance.

ACTIVITY RESTRICTIONS

Does your child have any restrictions for physical activities? ☐Yes ☐No

If yes, a written note from your physician for the current school year, stating the restrictions is required and needs to be updated yearly.

EMERGENCY CARE

This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health and safety of the student. In case of an emergency, if the school is not able to contact me, I give permission to take the student to the nearest hospital or appropriate facility for medical attention. This medical information may be shared with school personnel, EMT's, and hospital personnel as needed. If it is necessary to contact an ambulance, it will be the responsibility of the parent/guardian to pay for this service. I understand a copy of this information will be sent with my child to the hospital. If I cannot be reached by telephone in the event of an emergency involving:

____(student's name).

Please send my child to ______________________ or any available medical service.
(Hospital Preferred)

This information is current and correct; I understand that it is my responsibility as the parent/guardian to notify the school of new or existing health concerns or any changes in contact information. I understand that this health history form must be updated every school year.

______________________ ______________________
Parent/Guardian Signature Date

______________________ ______________________
Printed Name Phone number