

CURRENT HEALTH INFORMATION

Every student must have this form on file!
Please complete and return to the office by **August 22, 2019**.

Student Name: _____ Grade: _____

Parent/Guardian Name: _____

Physician: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

PLEASE SELECT ONLY THOSE ITEMS DIAGNOSED BY A DOCTOR:

Yes No Asthma? Medications used (including dosage): _____

Yes No Diabetes? Insulin? _____

Yes No Seizures or Epilepsy? Type of seizures: _____
Medications used: _____

Yes No Heart disease or bleeding disorder? Medications used: _____
Precautions/restrictions: _____

Yes No Allergies. Food: _____ Medication: _____ Other: _____
Medications used: _____
Epi-pen at school: Yes No

Yes No Physical Disability – Specify: _____

Yes No Does your child wear corrective lenses?

Yes No Serious illness, surgery, or accidents during the PAST YEAR that may affect school performance?
Specify: _____

Yes No Is your child taking any other medications? Medication name and dosage: _____
Reason for medication: _____

Yes No **Wisconsin Statute 118.29(2) Any school employee or volunteer so authorized: 1) May administer any drug which may lawfully be sold over the counter without a prescription to a pupil in compliance with the written instruction of the pupil's parent or guardian if the pupil's parent or guardian consents in writing. 2) May administer a prescription drug to a pupil in compliance with the written instruction of a practitioner if the pupil's parent or guardian consents in writing.**
Must medication be taken during school hours?

(If yes, obtain appropriate forms from the school office.)

Other Health Concerns: _____

Additional information you care to share: _____

Immunizations received this past summer? (Specific dates required)		Varicella _____	Date _____		
DTaP _____	Date _____	Polio _____	Date _____	TDap _____	Date _____
MMR _____	Date _____	Hepatitis B _____	Date _____	Other _____	Date _____

I understand this information will be shared in a confidential manner with my child's teacher(s) and the Public Health Nurse consultant to the school to best meet the health and education needs of my child.

Signature of Parent/Guardian