Washington County Public Schools

Student Health Information Form

☐ *Male* ☐ *Female*

Student Name *(Last, First, Middle)* ***Birth Date*** ***Grade***

Parent/Guardian Name *(Last, First, Middle)* ***Home Phone***

Mother's Cell Phone ***Father's Cell Phone*** ***Best Daytime Contact***

Emergency Contact ***Phone Number***

Primary Care Provider ***Phone Number***

Health Insurance **: Medicaid _____FAMIS_____Other_____No Health Insurance_____**

ALLERGIES: Medications ☐ Yes ☐ No, Please Specify_____; Food ☐ Yes ☐ No, Please Specify_____
Insect Bites ☐ Yes ☐ No; Other Allergies: Please Specify_____

EPIPEN ☐ Yes ☐ No: Why prescribed?_____ INHALER IN USE ☐ Yes ☐ No
(*Children who have EpiPens & Inhalers prescribed by a physician should have the medication available in the school clinic and for field trip*)

TO BE COMPLETED BY PARENT/GUARDIAN. PLEASE ANSWER THESE HEALTH HISTORY QUESTIONS ABOUT YOUR CHILD

Please circle Y if "yes" or N if "no", explain all "yes" answers in the space provided below.

Any Health Concerns	Y	N	Hospitalization or E.R. Visit (in the last 12 months)	Y	N	Concussion	Y	N
Is your child under the care of a physician for a medical condition	Y	N	Any Broken Bones or Dislocations	Y	N	ADHD/ADD	Y	N
Any Daily Medications	Y	N	Any Muscle or Joint Disorder/Injuries	Y	N	Bleeding Problems	Y	N
Any Problems with Vision	Y	N	Any Neck or Back Disorder/Injuries	Y	N	Heart Problems/Chest Pain	Y	N
Uses Contacts or Glasses	Y	N	Problems Walking or Running	Y	N	High/Low Blood Pressure	Y	N
Problems Hearing	Y	N	Urinary Tract Problems	Y	N	Problems Breathing or Coughing	Y	N
Problems with Speech	Y	N	Stomach/Bowel Problems	Y	N	Asthma Treatment (past 3 years)	Y	N
Sleep Concerns	Y	N	Weight Gain/Loss	Y	N	Seizure Treatment (past 3 years)	Y	N
Migraines/Headaches	Y	N	Dental Braces, Caps, or Bridges	Y	N	Diabetes	Y	N
Anxiety/Depression	Y	N	Requires a Special Diet	Y	N	Hypoglycemia	Y	N
Fainting/ Blackout	Y	N	Requires assistance with daily activities or with medical equipment	Y	N	Other	Y	N

Please explain all "yes" answers here. For illness/injuries/etc., please include the prescribing/treating physician.

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_____

_____

Please list the medications/treatments (including frequency) taken at home and required during the school day: (*Administration of prescription medications or medical treatments performed at school will require a physician order, and parent signed medication authorization form.)*

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Over the Counter Medications Needed at School (*Over the counter medications must be provided by a Parent or Guardian who must also sign an Over-the-Counter Medication Form.*)

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I give permission for release and exchange of information on this form between the school nurse, health care provider, and appropriate faculty and staff for confidential use in meeting my child's health and educational needs in school.

_____

Parent/Guardian Signature *Date*

Date	Reason for Clinic Visit