School District of Washington

Health and Emergency Information Form
School Building: _____
School Year: _____

Student Name: _____ Preferred Nickname: _____

Gender: F/M Birthdate: ____/____/____ Grade: _____ Home Room Teacher: _____

Name of person completing this form: _____

Does the student reside with you? Yes/No Relationship to Student: _____

Student's Physician: _____ Phone Number: _____

If no change in health history or medications from last year please initial here and just sign back of form: _____

Medical History

COMPLETE THE FOLLOWING REGARDING HEALTH CONCERNS THAT PERTAIN TO YOUR CHILD

Does your child take daily medications at home? No ____ Yes ____
Does your child take daily medication at **school**? No ____ Yes ____
Does your child need to have emergency medication at school? No ____ Yes ____

Name of Medication	Dosage	Times Taken	Reason for Taking

List: Childhood diseases with dates including Chicken Pox, serious illness and injuries: _____
_____

Surgeries/operations (provide age at time of surgery): _____
_____

Conditions that prevent PE participation: _____
_____

DOES YOUR CHILD HAVE:

An allergy to any foods, medications, insects, latex or other substances? No__ Yes__

If Yes, please explain in detail: _____
List Symptoms: _____
What medication(s) or treatment is used to treat the allergy? _____
Has your child ever had a severe "anaphylactic" reaction requiring emergency care (list date)? _____

Other Allergies No__ Yes__ Please list: _____
Has the allergy required medication in the past:
No__ Yes__ Comments:_____

Bee Sting Allergy No__ Yes__ Describe the reaction: _____
Any difficulty breathing? _____ Need emergency medication? ____

Asthma No__ Yes__ Triggered by: _____ Treatments: _____
Diagnosed by doctor: _____ Date: _____

Diabetes No__ Yes__ Takes insulin? No__ Yes__ Date diagnosed: _____

Epilepsy/Seizures No__ Yes__ Describe seizure: _____
Date of last seizure: _____ Medications: _____
Is student currently under a doctor's care for seizures? No___Yes___

Head injury No__ Yes__ Includes: concussion, or being knocked unconscious, or any major blow to the head such as in a car accident or fall.
Date of incident/accident/injury: _____
Description of injury: _____

Heart condition No__ Yes__ Describe: _____
Any physical restrictions? _____
Any medications? _____

Heat related illness No__ Yes__ Includes: heat cramps, dizziness, headache, passing out.
Describe: _____

Bone or joint problem No__ Yes__ Describe: _____
Any physical restrictions? _____

Are there any other concerns or medical/family history which might be important for the nurse to know? _____
_____

Special Procedures Required: _____
_____

Please check any of the following that apply then explain in the space provided below:

Eyes: Glasses ____ (reading ____ distance ____) Contacts ____ Crossed eyes ____ Lazy Eye ____ Color Blind ____
Other Vision difficulty or disorder (explain): _____

Ears: Frequent ear infections ____ Tubes ____ Other Hearing difficulty (explain) _____
Hearing aid: Right ____ Left ____ Wear at school? No ____ Yes ____

Other Concerns- Please check all that apply to your child:

☐ Freq. Headaches	☐ Down Syndrome	☐ Psychiatric/Psychological Disorder
☐ Migraine	☐ Autism or PDD	☐ Depression
☐ Dizziness	☐ Neurological Disorder	☐ Anxiety/Panic Attacks
☐ Fainting	☐ Freq. Nosebleeds	☐ Bowel Disorder
☐ Nervous Habits	☐ Dental Problems	☐ Bladder Disorder
☐ Phobia (fears)	☐ Freq. Sore Throat	☐ Kidney Disease or Disorder
☐ ADD/ADHD	☐ Thyroid Disorder	☐ Lung Disease
☐ Dyslexia/Learning Disorder	☐ Muscular/Orthopedic issue	☐ Cystic Fibrosis
☐ Sleep Disorder	☐ Cerebral Palsy	☐ Anemia/Sickle cell or Blood Disease or Disorder
☐ Menstruation Concerns	☐ Muscular Dystrophy	☐ Appetite or Eating Disorder
☐ Cancer	☐ Skin Rashes or Growths	☐ Other: _____
☐ Hyper/Hypothyroidism	☐ Bronchitis/Chronic Upper Respiratory Infections	

Please provide explanation for any of the above checked items:
_____
_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact the physician indicated on this form and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements deemed necessary, including transporting my child to the nearest hospital.

Father's/Guardian Signature _____ **Date:** _____

Mother's/Guardian Signature _____ **Date:** _____

These signatures convey consent, which will be valid, until the appropriate guardian provides written termination to the School District of Washington or the end of the current school year.