STUDENT HEALTH INFORMATION UPDATE 2012-2013

Wilson Creek School District | PO Box 46 – 400 Navar Street | Phone: 509-345-2541 | FAX: 509-345-2288

The information below is to help staff understand any health concerns that might affect your child's safety or learning.

STUDENT NAME: _____
First *Middle* *Last*

DATE OF BIRTH: _____ **Please choose:** ☐ Male ☐ Female **Grade:** _____

MEDICAL HISTORY

☐ **Over the last school year, my child developed the following health problem(s):**

_____ Asthma ☐ Will need inhaler at school ☐ Seen in hospital/emergency room in last five years?

_____ Severe allergy requiring Epi-pen? Allergy to: ☐ Food ☐ Bees/insects ☐ Plants ☐ Animals ☐ Drugs

_____ Diabetes ☐ Requires insulin injection

_____ Seizure disorder _____ Heart condition

_____ Frequent or severe headaches _____ Behavior or emotional concerns

_____ Other – please explain any health concerns you think we should know about at school.

Does your child wear glasses/contacts? ☐ No ☐ Yes Does your child wear hearing aides? ☐ No ☐ Yes

Does your child have a life-threatening health condition? ☐ No ☐ Yes **(If yes, plan to meet with the school nurse.)**

☐ **My child has not developed any health problems.**

MEDICATION

Does your child take any medication? ☐ No ☐ Yes Reason for taking medication: _____

Will medication be needed at school? ☐ No ☐ Yes **If yes, please contact the school for the proper form. We must have a new form every year before medication may be given.**

MEDICAL – DENTAL CARE **If you want help, please include contact information.**

I request help finding **(circle one)** insurance medical and/or dental care for my child.

AUTHORIZATION FOR SHARING HEALTH INFORMATION: I understand that the information given above may be shared with some school staff to provide for the health and safety of my child.

Parent/Guardian Signature: _____ Date: _____