STUDENT HEALTH INFORMATION UPDATE 2013-2014
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
Diet-controlled food allergy/intolerance	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	
	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
I request help finding (circle one) insurance med	lical and/or dental care for my child. include contact information.
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: