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

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

(Washington High School or Washington Middle School students only)

I hereby grant permission to the SCHOOL NURSE at Washington High School or Washington Middle School to administer Acetaminophen 325 mg 1 to 2 tablets when necessary for headache, toothache, or minor aches and pains. ☐ Yes ☐ No

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.