CURRENT HEALTH INFORMATION

*** Please complete and return to school tomorrow.**

Student ______________________ Birthdate ______________ Grade ____________

Address ______________________ City ______________ Zip ____________

Parent/Guardian ______________________ Home Phone ______________ Work Phone ____________

Physician ____________________ Address ______________________ Phone ____________

Dentist ____________________ Address ______________________ Phone ____________

Yes	No	*PLEASE CHECK ONLY THOSE ITEMS DIAGNOSED BY A DOCTOR*
_______	_______	Asthma? Medications used (including dosage):________________________ ____
_______	_______	Diabetes? Insulin ________________________
_______	_______	Seizures or Epilepsy? Type of seizures:________________________ Medications used ________________________
_______	_______	Heart disease or bleeding disorder? Medications used: ________________ ________________ Any precautions/restrictions________________
_______	_______	Allergies. Food: ____________ Medication: ____________ Other:____________ ________________ Medications used:________________ Epi-pen at school _______ Yes ________ No
_______	_______	Physical Disability – Specify:________________________
_______	_______	Does your child wear corrective lenses?
_______	_______	Serious illness, surgery, or accidents during the PAST YEAR that may affect school Performance – Specify:________________________
_______	_______	Is your child taking any other medications? Medication name and dosage:_______ ________________ Reason for medication:________________
_______	_______	Must medication be taken during school hours? (If yes, obtain appropriate forms from the school office.)
		All Other Health Concerns: ________________________ ____

Wisconsin Statute 118.29(2) Any school employee or volunteer so authorized: 1) May administer any drug which may lawfully be sold over the counter without a prescription to a pupil in compliance with the written instruction of the pupil's parent or guardian if the pupil's parent or guardian consents in writing. 2) May administer a prescription drug to a pupil in compliance with the written instruction of a practitioner if the pupil's parent or guardian consents in writing.

Immunizations received this past summer? (Specific dates required) Varicella_________ Date____________

DTaP _________ Date____________ Polio _______________ Date___________ TDap_________ Date__________

MMR _________ Date____________ Hepatitis B__________ Date___________ Other_________ Date__________

Additional information you care to share:____

____

I understand this information will be shared in a confidential manner with my child's teacher(s) and the Public Health Nurse consultant to the school and/or the school nurse to best meet the health and education needs of my child.

____

Signature of Parent/Guardian