Cambridge School District
Health History

PLEASE PRINT

Child's Name (Last)_____ (First)_____ (MI)_____ Birthdate: _____
Address: _____ Primary Phone: _____
(Number, Street) (City) (Zip)
SCHOOL: Cambridge Elementary School_____ Nikolay Middle School_____ Cambridge High School GRADE:____
Primary Physician: _____ City:_____ PHONE:_____ FAX:_____
Dentist: _____ City:_____ PHONE:_____
Date of last dental exam: _____

Dear Parents and Students: In order to update our school health records and to become aware of any health concerns, we request that you complete this form. Additional information or comments are also welcome. Should your child have a medical concern during the school year, please notify the school. The school nurse is available for consultation or to receive referrals. She may be contacted through the school office phone numbers at extension 4104. The following screening programs will be conducted this year: Vision –4K, 5K, 1, 3, and 5; Hearing – 4 K, 5K, 1 and 3. Parents will be notified only if screening results indicate the student should be seen by a physician; other results are available on request.

Please indicate which of the following apply to your child. If you answer 'yes' to any item, please provide further explanation:

Y	N	Condition	Y	N	Condition
		Allergies:			**Hepatitis:**
		Seasonal:			**Birth Defects:**
		Reaction to insect bites:			**Orthopedic problems:**
		Animal:			**Emotional problems:**
		Food:			**Skin rashes:**
		Drug:			**Bedwetting:**
		Other:			**Hyperactive:**
		Asthma:			**Surgical Procedures:**
		Diabetes:			
		Epilepsy:			**Accidents:**
		Digestive Disorders:			**Injuries:**
		Heart Condition :			**Diseases or conditions which may affect their education:**
		Mental Health:			
		Hemophilia:			**Recent Immunizations:**

EYES				EARS			
Y	Year	**N**		**Y**	Year	**N**	
			Is or was cross-eyed				Frequent Infections
			Wears glasses				Any ear surgery
			Wear contacts				Has hearing loss
			Any vision loss				Has hearing aid (s)
			Any other eye problem				Any other ear problem
			Any eye surgery				Tubes in ears

Is your child taking medication? _____No _____YES, please explain:_____
Name of medication:_____ Taken during school hours? ____No ____Yes (**PLEASE COMPLETE A MEDICATION FORM)**

If there are any limitations on your child's activities at school, work, or otherwise, please list them and the reasons for the limitations below. If so, a dated note from the student's primary physician should state the reason, the amount of activity permitted, and the length of time this is to be in effect:

Please list any significant health problems of other family members: (Example: diabetes, cancer, heart disease, high blood pressure, scoliosis (curvature of the spine).

Pertinent updated health information for your child may be shared with the school he/she is attending. I give permission to have my child participate in the screening programs for vision and hearing.

_____ _____
Parent's signature Date this form completed

CAMBRIDGE SCHOOL DISTRICT
Cambridge Elementary School, 802 W. Water St., Cambridge, Wi 53523
Phone-(608)423-3261, Fax (608)423-9869

Dental Examination

Student's Name _____ Birth Date _____

Parent or Guardian _____

TO THE PARENT: We urge you to take your child to the dentist before school begins for a dental examination and any necessary treatment. When the examination/treatment are completed and the dentist has signed this form, **please return this form to the school**.

TO THE DENTIST: Please check one of the following and sign this form.

_____ Child is involved in a preventive dental program.
_____ All necessary dental work has been completed.
_____ No Dental work is necessary.
_____ Treatment is in progress.

_____
Signature of Dentist Date

_____
Printed Name of Dentist

Address _____

Phone: _____

Please return this form to the School (address listed above). Thank you.

State of Wisconsin
Department of Regulation and Licensing

KINDERGARTEN EYE HEALTH EXAMINATION REPORT

Student's Name _____ Birth Date _____ Sex _____

Parent or Guardian _____ Phone _____

Address _____ County _____

School/Kindergarten _____ City _____

Date entering Kindergarten _____

The State of Wisconsin encourages parents of Kindergartners to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician by December 31 of the child's first year in school. An examination or evaluation should include, at a minimum, the elements listed below. (By checking the box, the examining doctor is indicating that the element checked was performed.)

- ❒ Brief history (general health and eye health) of the child, including family history
- ❒ General external observation of the child's eyes and surrounding structures
- ❒ Ophthalmoscopic examination through an undilated pupil
- ❒ Gross measurement of peripheral vision
- ❒ Evaluation of eye coordination and function (alignment and motility)
- ❒ Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended: ❒ Yes ❒ No

Date of examination:

_____

Doctor/Physician Signature:

_____

Print or stamp:
Doctor/Physician Name
Address
Phone

IMPORTANT NOTICE TO PARENTS

This examination is not required by law. Disclosure of the information noted above is necessary to comply with the statutory purpose as outlined in s. 118.135, Wis. Stats.

Disclosure of this information is voluntary and there is no penalty for non-compliance.

You are encouraged to provide a copy of this form to the school and keep a copy for your record.

Consent of parent or guardian: I agree to release the above information on my child to appropriate school authorities and consent to my child obtaining an eye examination.

Signature _____

Date _____