

# Wisconsin Heights School District Health Survey/Information

## 2022-23

This form must be updated annually to ensure student health records are up-to-date.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

YES <input checked="" type="checkbox"/>	NO <input checked="" type="checkbox"/>	
		<b>Severe reaction to insect stings?</b> Type: Reaction: <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Swelling <input type="checkbox"/> Cough <input type="checkbox"/> Other _____ Treatment(s):
		<b>Food allergies? If yes...</b> Trigger(s): Reaction(s): <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Swelling <input type="checkbox"/> Cough <input type="checkbox"/> Other _____ Treatment(s):
		<b>Other allergies? If yes...</b> Trigger(s): Reaction(s): <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Swelling <input type="checkbox"/> Cough <input type="checkbox"/> Other _____ Treatment(s):
		<b>*Epi-pen at School:</b> <input type="checkbox"/> In school Health Office <input type="checkbox"/> With Student ( <u>requires physician and parent's signature</u> )
		<b>Asthma? If yes, check one:</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Trigger: <input type="checkbox"/> Exercise <input type="checkbox"/> Illness <input type="checkbox"/> Allergies Reaction:
		<b>*Inhaler at School:</b> <input type="checkbox"/> In school Health Office <input type="checkbox"/> With Student ( <u>requires physician and parent signature</u> )
		<b>Heart Condition? If yes identify</b> _____ Describe... Treatment(s): Restriction(s):
		<b>Vision loss? (Not corrected by glasses) If yes, describe:</b>
		<b>Hearing loss? If yes, describe:</b> Hearing Aid(s) <input type="checkbox"/> Yes ( L, R, Both) <input type="checkbox"/> No
		<b>Mental health? (i.e. ADD, ADHD, depression, anxiety) If yes, describe:</b>
		<b>Diabetes? If yes, describe action plan: (nurse will follow up with family about specific action plans)</b>
		<b>Seizures? If yes describe action plan: (nurse will follow up with family about specific action plans)</b>
		<b>Migraines / Headaches? If yes, describe: Treatment:</b>
		<b>Physical limitations? If yes, describe:</b>
		<b>Student takes medication at home? If yes, list medication(s):</b>
		<b>Student will take medication at school? If yes, list medication(s):</b>
		Medication Name: _____ Dose: _____ Frequency: _____ Taken at School: Y N
		Medication Name: _____ Dose: _____ Frequency: _____ Taken at School: Y N

**\*Students who require prescription or over the counter medication during school hours must have a current medication consent form completed and signed by their parent/guardian and/or medical practitioner.**

This form must be submitted to the office prior to medication being administered or taken at school. Medication must come in the original container and be appropriately labeled. Forms can be found on the district website or in the school office.

**Additional Pertinent Medical Information:**

The parent/guardian signature below allows the school to share student health concern information with school staff members, bus drivers, and coaches/advisors that may come in contact with the student.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_