WESTVIEW SCHOOL CORPORATION

Annual Health Information Update

Please Circle School: **WJSH WES SES MES TES**

Student: _____ **School Year:** _____ **Grade:** _____

Date of Birth: _____ **Sex:** _____

Mother/Guardian Name _____ Home Ph: _____ Work Ph: _____ Cell Ph: _____

Father/Guardian Name: _____ Home Ph: _____ Work Ph: _____ Cell Ph: _____

Dr. Name: _____ Dr. Phone: _____

Emergency Contact #1 (other than parent) _____ Ph: _____

Emergency Contact #2 (other than parent) _____ Ph: _____

Emergency Medical Treatment Authorization: I understand that every effort will be made to contact the parent/guardian or designated emergency contacts in an emergency: however, in the event they cannot be reached, I hereby authorize the school to secure Emergency medical treatment for my child if necessary. This action will include but not be limited to:

1. Providing supportive care of minor first aid treatment.
2. Giving acetaminophen (generic for Tylenol) for fever of 102 or greater. .Giving diphenhydramine (generic for Benadryl) by mouth for allergic reaction to food or insect bite.
3. *Allow my student's emergency contact to do the following:* ***(mark all that apply)***
   a. **Transport student /give permission for the student to be released from school** _____
   a. **Authorize and/or dispense over-the-counter, one time medications** _____

Please check if your child has any of the following CURRENT conditions:

_____**Diabetes:** ___**Type 1** ____**Type 2** _____**Heart Condition** _____**Seizure Disorder**
_____**Other:** _____ _____**Asthma** _____**Bleeding Disorder**

_____**Allergies:** (circle) Insect Sting / Foods / Medication / Other

List Allergies: _____

* If your child has Life-threatening allergies, does your child require an Epi-Pen while at school? ___Yes ___No

* Are dietary restrictions required for your student's food allergies? ___Yes ___No

* If your child has Asthma, does your child require an inhaler or nebulizer meds at school? ___Yes ___No

If you indicated that your student has any of the above health concerns, please have your physician complete a Westview Schools Health Care Plan, located in the School Nurse Office

____ADD/ADHD ____Frequent ear infections ____Frequent nose bleeds ____Stomach problems

____Vision Impaired (glasses/contacts) ____Hearing Impaired (hearing aid) ____Orthopedically Impaired (physical limitations)

Please list ALL your child's medications:

Medication	Dose	Frequency	Reason

CONTINUE ON REVERSE SIDE

NOTE:
All prescription and non-prescription medication to be administered at school must be brought in the original container with written instructions, including medication name, dosage, and time of administration. Herbal and homeopathic preparations that are not FDA approved will not be administered.

Surgical History *(procedure/date):*_____
_____

Comments regarding your child's physical or emotional health**:** _____
_____

This form will remain valid throughout the entire school year. Information is shared as needed with teachers and staff to aid in your child's education. Thank you for your cooperation.

Signature of Parent/Guardian: _____ **Date:** _____