West Nodaway R-1 Health History Form

Student Name: ___________________ __________________ _______________ Date of Birth: ________________
(Last) (First) (Middle)
Address: ____
Parent/Guardian to Contact if Child is Sick:

Parent/Guardian________________________ Parent/Guardian________________________
Home Phone #: _________________________ Home Phone #: _________________________
Cell Phone #: ___________________________ Cell Phone #: ___________________________
Work Phone #: __________________________ Work Phone #: __________________________
Place of Employment: ____________________ Place of Employment: ____________________
Hours of Employment: ___________________ Hours of Employment: ___________________

In Case of Emergency and Parent/Guardian CANNOT be Reached:
Contact #1 Name: _____________________Phone#: ____________________ Relationship: _________________
Contact #2 Name: _____________________Phone #: ____________________ Relationship: _________________

MEDICATION:
Does your student take medications? Yes ☐ No ☐
If YES, Diagnosis/Reason: ____

Medication	Dose	Time (s)

Do you have health insurance? Yes ☐ No ☐ Medicaid? Yes ☐ No ☐
Medical Insurance Number: _______________________ Medical Insurance Company: __________________

HEALTH INFORMATION:
Physician's Name: _______________________ Phone: ____________________ Date of Last Visit: ___________
Dentist's Name: _________________________ Phone: ____________________ Date of Last Visit: ___________

Does the school have permission to take your child to your family physician or another physician in the event you cannot be contacted? Yes ☐ No ☐

In the event of a medical emergency, the school will seek appropriate medical attention for your child.

MEDICAL HISTORY: Has your student or does your student have any of the following illnesses or diseases:
Allergies (food, medications, animals, environments).......Yes ☐ No ☐ Head Injury/Concussion ....Yes ☐ No ☐
Asthma..Yes ☐ No ☐ Hearing Problems ....Yes ☐ No ☐
Attention Deficit/Hyperactive Disorder..... Yes ☐ No ☐ Heart Problems/Murmur.............Yes ☐ No ☐

Behavior Problems...Yes No Migraine Headaches ....Yes
No
Bladder Problems...Yes No
Bowel Problems..Yes No Pneumonia...Yes
No
Broken Bones..Yes No Seizure disorder..................................Yes
No
Dental Problems...Yes No Surgery..Yes
No
Diabetes...Yes No Tubes in
Ears....................................Yes No
Frequent Ear Infections................................ Yes No Wears Glasses/Contacts......................Yes
No

Please explain YES answers here: ____
____

Does your student have any physical limitations or handicaps that the school should be aware of? If so, please explain: ____

PARENTAL PERMISSION FOR MEDICATIONS:
Please mark YES/NO if your child can receive the following medications to treat minor illness/injury:

YES NO For signs/symptoms of severe allergic reaction: Epipen (This medication will be used only for an emergency in which case your child may be unable to breathe due to severe allergic reaction. It could save your child's life!)
YES NO For signs/symptoms of mild allergic reaction: Benadryl
YES NO For minor indigestion/upset stomach: Tums
YES NO For minor throat irritations/cough: Cough drops/ Guaifenesin (Robitussin) Cough Syrup
YES NO For minor aches/ fever/ headache: Tylenol
YES NO For minor pain/ ache/ headache: Ibuprofen

We have received instructions for dosages on all the above medications from Dr. Susan Watson, MD, per standing orders for your convenience. They will be available at school and can be given when needed, with your permission. No additional medication will be given to your child by school staff without a prescription from your doctor. This includes over-the-counter medications.

The above information is necessary for the student's record and is confidential. I grant permission for the exchange of this information with other WN staff members, as needed, to facilitate my child's health care.

Information given by: Mother ☐ Father ☐ Guardian ☐

Signed: ________________________________ Date: ___________________

Please review, make corrections, sign, and date:
Annual Review: ___________________________________Date: __________________Child's Current Grade: ____
Annual Review: ___________________________________Date: __________________Child's Current Grade: ____
Annual Review: ___________________________________Date: __________________Child's Current Grade: ____
Annual Review: ___________________________________Date: __________________Child's Current Grade: ____