



Health Services use only:
Reviewed/Entered by _____

2019-2020
STUDENT HEALTH HISTORY
To be completed by parent/ guardian

School _____ Grade _____ Homeroom Teacher _____

Student Name _____ Gender _____ Date of Birth _____

Guardian Name _____ Relation _____ Phone1 _____ Phone2 _____

Guardian Name _____ Relation _____ Phone1 _____ Phone2 _____

Emergency Contact1 _____ Relation _____ Phone _____

Emergency Contact2 _____ Relation _____ Phone _____

Does your child have any health concerns the nurse needs to be aware of? No Yes

If YES, please describe _____

My child has been diagnosed with a Serious or Life-Threatening Health Condition (Please describe):

- Severe Allergic Reaction _____
- Asthma _____
- Diabetes _____
- Seizure Disorder _____
- Heart Condition _____
- Chronic or recurring illness _____
- Other Serious Health Concern _____

My child requires special procedures for their health condition: No Yes (list): _____

MEDICATIONS

The parent/guardian (not the student) must provide and deliver all medications to the school nurse in the original or pharmacy-labeled container. Written permission is required before any medication can be given at school. Medication forms are available in your school health clinic or on the WCS Health Services website.

No Yes **Emergency Medications needed at school** (list): _____

No Yes **Other Medications needed at school** (list): _____

No Yes **Medications needed at home** (list): _____

No Yes **Medication Allergies** (list): _____

All health information is considered confidential. Relevant health information will be shared with staff and emergency responders only as necessary to maintain and promote the student's health and safety.

Parent/Guardian Signature _____ Date _____