WESTFIELD WASHINGTON SCHOOLS: Health History Form
Kindergarten & Grade 1

In order to provide your child with the best educational experience at Westfield Washington Schools, school personnel must understand your child's health needs. Please complete the front and back side of this form, **a signature from your child's physician is required.** Make sure you sign the back page under parent signature. Return this completed form to your school before the first day of school.

Today's Date:_____ Student's Name:_____

Gender: M/F Birthdate:_____/_____/_____ Grade:_____ School:_____

Immunization Requirements:

Please complete the Immunization Record below or attach, Indiana Code requires the parents/guardians of a child who has enrolled in a school corporation to furnish **no later than the first day of school**, a written statement of the child's immunizations. A complete list of required immunizations is available on the Westfield Washington Schools website or upon request.

Students are not permitted to attend school until their immunization record is up to date in the school health office.

☐ **See attached immunization records**
OR enter information in the chart below
PLEASE RECORD MONTH/DAY/YEAR FOR DOSE

Vaccine	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6	DOSE 7
DPT/DTaP/DT							
IPV							
OPV							
MMR							
MEASLES							
MUMPS							
RUBELLA							
HEP. B							
VARICELLA							
HEP A							

HISTORY OF DISEASE (Include month/year of disease)

Chicken Pox:_____

(A written statement signed by a physician with the date/month of your child's history of chicken pox disease is required)

Rubella:_____ Diptheria:_____

Measles:_____ Whooping Cough:_____ Mumps:_____

Scarlet Fever:_____ Other:_____

MEDICAL HISTORY (Include date started, how often occurs and comments)

Arthritis_____ Asthma_____

ADD/ADHD_____ Bleeding Disorders _____

Diabetes _____ Hearing Problems_____

Heart Condition_____ Seizure Disorder_____

Concussion_____ Physical Disabilities_____

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Vision Problem_____ Freq. Nosebleeds_____

Recent Surgeries_____ Recent Hospitalization_____

Is your child under medical care for a health condition not indicated above? ☐ Yes ☐ No

If yes, explain_____

_____

_____

ALLERGIES (List type, reaction and if life threatening)

TYPE	REACTION(S)	LIFE THREATENING
		Y/N
		Y/N

MEDICATION HISTORY

Is your child taking any daily medication? ☐ Yes ☐ No

DRUG NAME	REASON	DOSE	FREQUENCY	STOP DATE

Will the medication be needed during school hours? ☐ Yes ☐ No
If YES, complete permission to give medication form. You must complete a form prior to any medication being given at school with the school nurse.

Date of last dental examination and any pertinent findings:
_____

Parent/Guardian Signature_____ **Printed Name** _____

Physical Examination:
This form must be signed by your physician prior to returning it to school

The Westfield Washington Schools require that each child entering kindergarten receive a physical examination by his/her private physician before enrollment in school. Dental exams are recommended, but not required.

_____ Normal/Typical physical findings _____ Abnormal/Atypical physical findings (specify)

Physician Comments/Notable findings: _____

_____

_____

_____ _____
Physician's Signature **Date**