WESTFIELD WASHINGTON SCHOOLS: Health History Form

Grades 2-12

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.

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

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

Immunization Requirements:

Please complete the immunization record below or attach a copy of your child's record. All up to date records must be on file with the school nurse by the first day of school. Students are not permitted to attend school until immunization records are up to date.

GRADES: 2 **3 Hepatitis B – 5 DTap – 2 MMR- 2 Varicella – 4 Polio**
GRADES: 3 to 5 **3 Hepatitis B – 5 DTap – 2 MMR- 1 Varicella – 4 Polio**
GRADES: 6 to 12 **3 Hepatitis B – 5 Dtap – 2 MMR- 2 Varicella – 4 Polio – 1 Tdap – 1 MCV4**

PLEASE RECORD MONTH/DAY/YEAR FOR DOSE

Vaccine	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6	DOSE 7
Dtap/DTP (5)							
Hepatitis A							
Hep B (3)							
MMR (2)							
Measles							
Mumps							
Rubella							
Polio (4)							
MCV4 (1)							
Tdap (1)							
Varicella (1 or 2)							

HISTORY OF DISEASE (Include month/year of disease)

Chicken Pox:_____ (Must provide month/yr of chicken pox disease)

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_____

Vision Problem_____ Freq. Nosebleeds_____

Recent Surgeries_____ Recent Hospitalization_____

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Is your child under medical care for a health condition not indicated on page 1? ☐ Yes ☐ No

If yes, explain_____

_____

_____

ALLERGIES (List type, reaction and if life threatening)

TYPE	REACTION(S)	LIFE THREATENING
		Yes or No
		Yes or No
		Yes or No

MEDICATION HISTORY

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

DRUG NAME	REASON	DOSE	HOW OFTEN

Will 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:

_____

Please contact the school nurse if you child has a chronic disease and will need medical accommodations at school.

_____ _____

Parent/Guardian Signature **Date**

_____

Printed Name