

HIGH SCHOOL STUDENT CURRENT HEALTH INFORMATION School Year _____
(This form is not required yearly)

Return this form ONLY if there are updates to your child's health record or your child is new to the district.

Student _____ Birthdate _____ Grade _____

DOES YOUR CHILD HAVE: (PLEASE CHECK YES OR NO – If yes, please indicate specific information that school personnel needs to know regarding the condition.)

Yes No

____ Asthma as diagnosed by a physician? Medication used (including dosage):
Inhaler: YES _____ NO _____

(If YES-obtain appropriate form from office or online)

____ Diabetes as diagnosed by a physician? Insulin _____

____ Seizures or Epilepsy as diagnosed by a physician? Type of seizures: _____
Medication used: _____

____ Heart disease or bleeding disorder as diagnosed by a physician? Medications used: _____
Any precautions/restrictions: _____

____ Allergies of significance to school performance? Please list: _____
Medication used: _____

Epi-pen at school YES _____ NO _____ **(If YES-obtain appropriate form from office or online)**

____ Physical Handicaps – Specify: _____

____ Does your child wear glasses or corrective lens?

____ Serious illness, surgery or accidents during the ***PAST YEAR*** that may affect school performance – Specify: _____

____ Any immunizations during the ***PAST YEAR?*** Please list immunizations and dates received: _____

____ Is your child taking any other medication? Medication name and dosage: _____
Reason for medication: _____

____ Must medication be taken during school hours?
(If YES-obtain appropriate form from office or online)

Wisconsin Statute 118.29(2) Any school employee or volunteer so authorized: 1) may administer any drug which may lawfully be sold over the counter without a prescription to a pupil in compliance with the written instruction of the pupil's parent or guardian if the pupil's parent or guardian consents in writing. 2) may administer a prescription drug to a pupil in compliance with the written instruction of a practitioner if the pupil's parent or guardian consents in writing.

Additional information you care to share _____

I understand this information will be shared in a confidential manner with school personnel to best meet the health and educational needs of my child.

Parent/Guardian Signature

Date

Phone Number