

WASHINGTON SCHOOL DISTRICT

Medical History Form

PLEASE COMPLETE FORM & RETURN AS SOON AS POSSIBLE



Name: _____ Birthdate: _____
Last First MI
School: _____ Grade: _____ Teacher: _____

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. It is very important to know of LIFE THREATENING conditions.

In order to provide a safe and healthy environment for your child, this information will be accessible to the following people: School Nurse, your child's teachers, office manager, personnel responsible for health room coverage and emergency medical personnel.

A.e Medical History: Check the ones that apply to your child and describe under the comment section.e

☐ ADHD/ADD	☐ Headaches	☐ Other: _____
☐ Anxiety/Panic Attack	☐ Hearing Problems	(explain)
☐ Asthma	☐ Heart Condition	☐ PE activity
☐ Bee Sting Allergy	☐ Kidney/urinary	☐ Limited _____
☐ Bowel Problems	☐ Muscle Disorder	☐ Not Limited _____
☐ Color Blindness	☐ Neurological Concern	☐ Explain: _____
☐ Cerebral Palsy	☐ Orthopedic Problems	_____
☐ Diabetes	☐ Seizures	_____
☐ Epi-Pen	☐ Vision Problems	_____
☐ Emotional Concerns		

Comments: _____

B.e ALLERGIES: List allergies your child has that may cause a problem at school:e

Cause of allergy: _____ Treatment: _____

Cause of allergy: _____ Treatment: _____

C.e MEDICATION: Include prescription, nonprescription and herbal medications.e

Name	Used to treat	Taken at School?
_____	_____	Yes ☐ No ☐
_____	_____	Yes ☐ No ☐
_____	_____	Yes ☐ No ☐

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by the parent/guardian and authorizing physician and returned to the School Nurse.

D.e List any other operations, injuries, or hospitalizations. Give dates: _____e

E.e Does your student wear glasses? Yes ☐ No ☐ Contacts? Yes ☐ No ☐

From the Desk of the School Nurse