Student Health Record

School Nurse: 715-356-3282 Ext. 4417
Fax: 715-358-3789

**To meet your student's health needs at school and school related events, we request the following information. Please complete even if no health needs exist.*

Student's Name: _____ **Date of Birth:** _____

GENERAL

Do you consider your student to be in good health?
☐ Yes ☐ No,
Explain:

Does your student have any medical diagnosis or chronic illnesses?
☐ Yes ☐ No,
Explain:

Is a physician treating your student at this time?
☐ Yes ☐ No,
Explain:

Has your student had any surgery(s) or ever been hospitalized? ☐ Yes ☐ No,
Explain:

Does your student wear glasses or contacts?
☐ Yes ☐ No,
Explain:

ALLERGIES

Does your student have any allergies *(food, insects, seasonal, other)*? ☐ Yes ☐ No,
Explain:

Does your student require dietary accommodations *(lactose intolerant, gluten free, other)*?
☐ Yes ☐ No,
Explain:

Is your student prescribed emergency epinephrine *(EpiPen, Epi Pen Jr. Auvi-Q, Neffy, other)*?
☐ Yes ☐ No,
Explain:

Does your student have a hearing aid or other medical device? ☐ Yes ☐ No,
Explain:

MEDICATIONS

Does your student take any medications? □ Yes □ No

Name of Medication	Reason for Medication	When given?
❖		
❖		
❖		

HEALTH CONTACT INFORMATION

Physician:		Phone #:
Dentist:		
Hospital:		
Insurance:	BadgerCare, ForwardHealth, Medicaid	☐ Yes ☐ No

Continued on next page…

Student Health Record

School Nurse: 715-356-3282 Ext. 4417
Fax: 715-358-3789

PAST MEDICAL HISTORY *This information will be utilized by the school nurse to develop a health plan for your student if necessary. Information regarding your student's health condition will be shared only with staff who need to know to assist your student in school.*

Please indicate if your student have or has your student ever had:	
Frequent ear infections	☐ Yes ☐ No
Hearing loss/deficit	☐ Yes ☐ No
Problems with eyes or vision *(History of Congenital Cataracts, Color Blindness, Retinoblastoma, other)*	☐ Yes ☐ No
Speech or language disorder?	☐ Yes ☐ No
Asthma or Reactive Airway Disease *(Current prescription for Albuterol – rescue – inhaler)*	☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No
Any Heart Problem *(Murmur, Congenital Defect, Surgery, other)*	☐ Yes ☐ No
Family History of Sudden Cardiac Death	☐ Yes ☐ No
Blood Pressure Irregularity	☐ Yes ☐ No
Postural Orthostatic Tachycardia Syndrome *(POTS)*	☐ Yes ☐ No
Anemia or Bleeding Disorder *(Sickle Cell, other)*	☐ Yes ☐ No
Cancer/Malignancy	☐ Yes ☐ No
Attention Deficit/Hyperactivity Disorder *(ADHD)*	☐ Yes ☐ No
Mental Illness, Emotional/Behavioral Disorder *(anxiety, depression, eating disorder, other)*	☐ Yes ☐ No
Autism Spectrum Disorder	☐ Yes ☐ No
Frequent Stomach Aches, Constipation, GERD, IBS, *other*	☐ Yes ☐ No
Nutritional Deficiency or Dietary Restrictions	☐ Yes ☐ No
Metabolic/Genetic Disorder: *(Down syndrome, Marfan, Turner, Ehlers-Danlos, other)*	☐ Yes ☐ No
Developmental disability or delay	☐ Yes ☐ No
Complications before/at birth, prematurity, or birth defects *(cleft lip/palate spina bifida, clubfoot, other)*	☐ Yes ☐ No
Kidney Disease/Disorder *(Congenital, other)*	☐ Yes ☐ No
Incontinence or Toileting Issue	☐ Yes ☐ No
Skin Problem *(eczema, psoriasis, reoccurring hives, other)*	☐ Yes ☐ No
Frequent Headaches/Migraines	☐ Yes ☐ No
History of Head Injury/Concussions	☐ Yes ☐ No
History of Serious Injury/Fractures/Burns	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Autoimmune disease *(Raynaud's, Juvenile idiopathic arthritis, Lupus, other*)	☐ Yes ☐ No
PANDAS	☐ Yes ☐ No
Epilepsy or Seizure Disorder	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No
Neuromuscular Disorder *(muscular dystrophy, spinal cord injury, other)*	☐ Yes ☐ No
Fine/gross motor deficits, limited use of arms or legs, muscle/bone/joint problems	☐ Yes ☐ No
Scoliosis	☐ Yes ☐ No
Tuberculosis/HIV/AIDS/Hepatitis	☐ Yes ☐ No
Any other significant medical history or change from completion prior:	

This form is completed upon enrollment, entry to 3rd grade, and entry to 6th grade. Please initial below:

Parent/Legal Guardian Initials: _____

Enrollment 3rd Grade 6th Grade