Winside Public School Health History

Student Name_____ Grade_____ DOB_____
Parent Name/ Guardian_____
Address_____City_____
Phone: (H)_____ (C)_____ (W)_____
Phone: (H)_____ (C)_____ (W)_____
List Current Medications _____
_____
Medications to be given at school: Yes_____ (please list below) No_____

Prescription Medication Name/Reason	**Dosage**	**Time**
_____	_____	_____
_____	_____	_____

****Each medication MUST be accompanied by a doctor's prescription and in the original bottle with label from the pharmacy.**

Does your child have any health condition now under treatment? No Yes
Please list:_____
Has your child been hospitalized anytime in the last 3 years? No Yes
Please list:_____
Has your child had any surgeries that may be of significance? No Yes
Please list:_____
Does your child have any eye, ear, nose or throat issues, including tonsil/adenoids removed? No Yes
Please list:_____
Does your child have any heart conditions? No Yes
Please list:_____
Does your child have allergies to food, medications, or seasonal? No Yes
Please list allergy and reaction:_____
Has your child had any head injuries, concussion, etc.? No Yes
Please list:_____
Does your child have any hearing, vision, or speech problems? No Yes
Please list:_____
Please list any special dietary needs or physical handicaps:_____
Does your child have diabetes? No Yes Does any family members have diabetes ? No Yes
Does your child have asthma? No Yes Does your child need an inhaler? No Yes

Child's Symptoms that may have a significance (Please check yes if the child exhibits the symptom and explain if necessary)

Yes No	**Yes No**	**Yes No**
___ ___ abdominal pain/cramping	___ ___ joint/muscle pains/swelling	___ ___ emotional concerns/anxieties
___ ___ chronic respiratory infections	___ ___ chronic fevers	___ ___ headaches
___ ____ frequent nosebleeds	___ ___ profuse sweats	___ ____ habitual cough
___ ___ pain in any part of the body	____ ___ frequent urination	___ ___ seizures/epilepsy
___ ___ frequent water intake	___ ___ shortness of breath	___ ___ fainting spells
___ ___ tires easily	___ ___ dizziness	___ ___ elimination problems/habits

Other (specify)_____ other(specify)_____
Is there anything more about your child's health that you think is important for us to know?
_____
_____

Parent/Guardian Initials for Consent:

_____I give permission for trained staff to provide prescription medication(s) as listed above. I agree to notify Winside Public School immediately with any changes in medication orders.

_____I give permission for trained staff to provide Tylenol, Ibuprofen, Tums, and cough drops (according to manufacturer dosage instructions) to this student for discomfort and verify that the student has taken these medications previously without problem.

Parent/Guardian Signature_____ Date_____

Authorization expires at the end of each academic year.