Health Services

Rev. Sept 2014

ANNUAL STUDENT HEALTH HISTORY 2014-15

WISD Health Services Department requires the following information to complete your enrollment. Health information you provide about your child is confidential and will be used to provide safe, informed care at school, and will only be communicated to WISD personnel who require it to better serve your child. **If your child has a medical condition, or medical changes occur during the school year, it is the parent/guardian's responsibility to notify the school nurse and update this information.**

Student Name: _____ **DOB:** _____ **Gender:** ☐M ☐F **Grade:** _____
Parent Name(s): _____ **Email:** _____
Cell #: _____ **Home #:** _____ **Work/Other #:** _____
Physician Name: _____ **Phone#:** _____ **Fax#:** _____

☐ **Student has no known health conditions OR no condition requiring regular medical care.**

MEDICAL PROBLEM REQUIRING REGULAR MEDICAL CARE:	EXPLAIN	MEDICATIONS/TREATMENTS
☐ **Allergic to** ☐ Insect stings ☐ Latex ☐ Seasonal allergies ☐ Food_____ ☐ Medicine _____ ☐ Other _____	Symptoms/Reaction:	☐ Allergy is mild. No medication or accommodations needed at school. ☐ Allergy is severe. Medication required. ***Allergy Action Plan Required - See School Nurse*** EpiPen? ☐Yes ☐No Benadryl? ☐Yes ☐No Other Medication?:
☐ **Asthma** ***Please provide current Asthma Action Plan if you child requires medications or treatments for asthma at school—See School Nurse.***	Age diagnosed: _____ Under medical care now? ☐ Yes ☐ No	Medications taken for asthma: At home: _____ At school: _____ ***Texas Law requires special permission form to carry inhaler at school—see school nurse.***
☐ **Behavioral, Emotional, Psych**		
☐ **Diabetes** ***A Diabetes Management & Treatment Plan is required for care at school—See School Nurse***	☐ Type 1 ☐ Type 2 Additional information:	
☐ **Seizures See School Nurse**		
☐ **Other**	☐ Hearing loss ☐ Vision loss ***not corrected*** with glasses/contacts ☐ Migraines ☐ Cerebral Palsy ☐ Spina Bifida ☐ Arthritis ☐ Muscular Dystrophy ☐ Scoliosis ☐ Crohn's Disease ☐ Gastric Reflux ☐ Irritable Bowel Syndrome ☐ Constipation	☐ Sickle Cell ☐ Hemophilia ☐ Heart condition/Heart surgery ☐ Cystic Fibrosis ☐ Tuberculosis ☐ Skin condition Other: _____ _____

MEDICATIONS NOT LISTED ABOVE CURRENTLY TAKEN: *All meds taken during school hours and school related activities must be brought to the clinic.* ***A special permission form is required for ALL medications****—see the school nurse.*

Medication	Dose/Time (s) given	Reason	Need at school?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

I understand and agree that a representative of Wylie ISD may provide topical first aid treatment (Caladryl Clear, Burn free Gel, Lubricating Eye drops) pursuant to a medical advisor standing orders, to my child at school, unless I opt out by checking (indicating No) in the follow boxes: ☐ Caladryl Clear ☐ Burn Free Gel ☐ Lubricating Eye Drops

Parent/Guardian Signature: _____ **Date:** _____