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: _____ (explain)
___	Anxiety/Panic Attack	___	Hearing Problems		
___	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?
_____	_____	Yese☐ Noe☐
_____	_____	Yese☐ Noe☐
_____	_____	Yese☐ Noe☐

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? Yese☐ No ☐ Contacts? Yese☐ Noe☐

From the Desk of the School Nurse