WA-NEE SCHOOL CORPORATION

HEALTH FORM

Student's name: ______________________ Grade: ________ School: ________________ Year: __________

Parent /Guardian: ______________________________ Telephone # (Home/Cell): ____________________

Physician: ____________________ Telephone #: ______________ Preferred Hospital: ______________

Your child's health and safety are very important to us. It is necessary that the school have current information about students with health problems. In order to do this, please supply the following:

My child may: ______ may not: ______ have Tylenol or Ibuprofen.

My child has (if YES, explain): Brief Explanation

_____Asthma ______________________________

_____Diabetes ______________________________

_____ADD/ADHD ______________________________

_____Heart Disease / Problems ______________________________

_____Physical Disabilities ______________________________

_____Hearing Loss / Vision Impairment ______________________________

_____Allergies (Please circle below) Is an Epipen required? Yes No Specify any treatment needed.

Bee sting Peanut Food Medication ______________________________

____

_____Other ______________________________

List of Medications: Name of Medication – How it is given:

At Home:

____

____

____

During School Hours:

____

____

____

Additional Information (use back if needed):

____

____

In order that my child may receive the best possible health care, I give permission for the information on this form to be shared with necessary school employees.

Date: ____________________ ______________________________

Parent / Guardian Signature