WAYNE COUNTY PUBLIC SCHOOLS
STUDENT HEALTH FORM

Dear Parents:

The following is a brief health form that must be returned to your child's teacher **as soon as possible**. This information will be reviewed by the school nurse and used to meet your child's health needs at school and in PE-Please use black ink.

School:		Homeroom Teacher/Grade: /
Student Name:	Date of Birth:	Home Phone:
Parent/Guardian:		Daytime Phone:
Parent/Guardian:		Daytime Phone:
Name of Doctor:		Phone:
Name of Dentist:		Phone:
Please Check Coverage Your Child Has: ___ Health Insurance ___Medicaid ___Military Coverage ___ None		
* Check What Your Child Will Need At School: ___SPECIAL DIET ___PE LIMITATIONS ___MEDICATIONS List Current Medication(s) Here:		
***List medication allergies and reactions here**:		

CHECK CONDITION(S) YOUR CHILD HAS BELOW **___ MY CHILD HAS NO HEALTH CONDITIONS**

__ADD/AHD __Allergies, Severe (See Below) __Asthma (See Below) __Autism __Cerebral Palsy __Concussion Date: _________ __Cystic Fibrosis	__Diabetes __Down's Syndrome __Epilepsy/Seizures (See Below) __Heart Problems (See Below) __Hemophilia/Bleeding Disorder	__ Leukemia/Cancer __Migraine Headaches __Neuromuscular Disease (See Below) __Muscular Dystrophy __Orthopedic Disability (See Below)	__Psychiatric Disorder __Renal/Kidney Disease __Juvenile Rheumatoid Arthritis __Sickle Cell Anemia __Ulcers/Gastric Reflux ___Other:____________ ____________________
___ Glasses/Contacts	___ Hearing Aid/Loss		

FOR CONDITIONS CHECKED ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION:

Severe Allergies (Plan)	What is your child allergic to? ______________________________________ * Is emergency medication needed at school for allergies? ___ No ___ Yes If yes, name: ____ Check the type of allergic reaction that occurs: ___HIVES ___SWELLING ___DIFFICULTY BREATHING ___OTHER: ________________
Asthma (Plan)	* Check only if medication is needed at school for asthma and/or student has missed school due to asthma _____ Date of last episode: ____________ List triggers: ____________________________
Seizures (Plan)	Check Type: ___ Febrile Only ___ Convulsive ___ Non-Convulsive When did last seizure occur?
Heart Problems	Check type: ___Functional Heart Murmur ___Heart Valve Condition ___Other: _________________________ * Is exercise limited? ___Yes ___No
Bone/Orthopedic/ Neuromuscular	Name of Problem: School Concerns:
Other Health Problem/Disability	Name of Problem: School Concerns:

(*) Indicates that physician authorization is required. See school nurse for information/forms.

______________________________________ ____________________

Signature of Parent/Guardian Date

White Copy: School Nurse *Yellow Copy: Teacher* *3/2018*