

CHEHALIS SCHOOL DISTRICT STUDENT MEDICAL HISTORY

1. STUDENT INFORMATION:

Student's Name: _____ Birthdate: _____ Male Female
Parent/Guardian: _____ Parent/Guardian: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Doctor/Clinic: _____ Phone: _____ Dentist/Clinic: _____ Phone: _____

The following information is needed to plan an appropriate program for your child, and to handle any emergencies. You may use the back of this form if you have any additional information. It is vital to your child's safety during the school day that if your child has a life-threatening health condition that may require medical services to be performed at school, you immediately notify your school's principal or school nurse. The necessary forms will be provided and a time will be arranged for you to meet with your child's school nurse.

2. MEDICAL HISTORY: (Check all that apply to your child)

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma (breathing problems) | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Vision issues (<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts) | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Seizures or convulsions |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hearing (Hearing Aids <input type="checkbox"/> Yes <input type="checkbox"/> No) | <input type="checkbox"/> Frequent nosebleeds |
| <input type="checkbox"/> Physical handicap | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Urine/bowel problems |
| <input type="checkbox"/> Other Please explain _____ | | |
| _____ | | |
| _____ | | |

3. ALLERGIES: Bees Foods Plants Drugs Animals Insects Other _____

Please describe the allergy and your child's reaction: _____

_____ Emergency treatment needed? No Yes

If yes, what treatment is needed? Medication: _____ Call 911

4. MEDICATION:

Is medication taken for any health problem? No Yes (Describe) _____
_____ Taken at Home School

Is your child's physical activity limited in any way? No Yes (how) _____

Parent Signature Date

I need information regarding low-cost health insurance.

Present Grade Level: _____ Teacher: _____ Room #: _____