**WESTFORD PUBLIC SCHOOLS**

**INFORMATION FOR STUDENT HEALTH RECORD**

*Please Print*

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| Student Name (Last, First, Middle) | Birth Date (MM,DD,YYYY) | Gender |
| Address ( Street, Town, State, ZIP code) | | |
| Guardian’s Name (Last, First) | Relationship to student | Phone Number |
| Guardian’s Name (Last, First) | Relationship to student | Phone Number |
| Entering Grade | Previous School | |
| Pediatrician | Location | Phone Number |
| Dentist | Location | Phone Number |

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| **Allergies:** ⧠ My child **HAS** the following allergies ⧠ My child has **NO** allergies  Is an Epi-pen prescribed? \*Yes\_\_\_ No\_\_\_ | | |
| Medication child is allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Environmental:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Bee/insect\_\_\_\_\_\_\_\_\_ | Latex\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Respiratory:** ⧠ My child **HAS** asthma ⧠History of reactive airway and/or wheezing ⧠ My child has **NO** respiratory history  If Yes:  Is an Inhaler currently Prescribed? \*Yes\_\_\_ No\_\_\_\_ Will you be providing an inhaler to the clinic? Yes\_\_\_\_\_ No\_\_\_\_\_\_ |

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| **Diabetes:** ⧠ My child **HAS** diabetes ⧠ My child has **NO** history of diabetes  If Yes:  Is insulin Prescribed? \*Yes\_\_\_ No\_\_\_\_ Treatment Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Seizures:** ⧠ My child **HAS** a history of seizures ⧠ My child has **NO** history of seizures  If Yes Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is medication prescribed? \*Yes\_\_\_ No\_\_\_\_ Will you be providing seizure medication to the clinic? Yes\_\_\_\_\_ No\_\_\_\_\_\_ |

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| **Please check all conditions that apply, and explain:** | | | | | |
| **Eye/ Ear** | **Cardiac/**  **Respiratory** | **GI/GU** | **Neurological** | **Other** | **Other Con’t** |
| ⧠ Eye Condition  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⧠Congenital Heart condition | ⧠Celiac | ⧠ Headaches | ⧠ADD/ADHD | ⧠Eczema/skin issues |
| ⧠Eyeglasses/contacts | ⧠Cystic Fibrosis | ⧠Constipation  ⧠Incontinence | ⧠ History of concussion  Date\_\_\_\_\_\_\_\_\_\_ | ⧠Anxiety | ⧠Nosebleeds |
| ⧠Ear condition  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⧠Heart Murmur | ⧠Lactose Intolerance | ⧠Migraines | ⧠Arthritis | ⧠Scoliosis |
| ⧠ Hearing aide | ⧠ History fainting | ⧠Frequent Stomach aches | Neuromuscular Condition  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⧠Autism spectrum disorder | ⧠Strep throat (Frequent history) |
| ⧠Multiple Ear infections  Tubes? Yes⧠ No⧠ | ⧠Lung Condition  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⧠Gastric reflux | ⧠Cerebral Palsy | ⧠Trouble sleeping |
| ⧠Kidney/bladder | ⧠Developmental Delay |  |
| **History of Hospitalization/Surgery?**  ⧠Yes ⧠No  Reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Emotional/Behavioral Concerns?**  ⧠Yes ⧠No  If yes explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Other Pertinent Medical History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **History Learning Disability?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⧠Current IEP? ⧠Current 504? | | | | | |

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| **Medications: Please list medications your child is taking** | | | |
| Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Time\_\_\_\_\_\_\_\_\_\_ | Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Required to be given in school?  ⧠Yes ⧠No |
| Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Time\_\_\_\_\_\_\_\_\_\_ | Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Required to be given in school?  ⧠Yes ⧠No |

I give permission to the nurse to speak with the above listed doctor/s to meet my child’s health and safety needs. YES NO ⧠

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature Required Date

If needed, I give permission to the nurse to share the following provided information with the appropriate school personnel to meet my child’s health and safety needs. YES NO ⧠

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