WASD --- Health and Emergency Information

Name_____Birthdate_____Grade____Teacher_____
Address_____ Phone_____
Guardian #1:_____ Guardian #2:_____

Employer: _____ Employer: _____

Work Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone:_____

Email address:_____

With whom does the student reside?_____

Which parent should we call first?_____

1) Person to be called if student becomes ill or injured while in school and parents cannot be located:

Alternate Name:_____ Phone:_____

Second Alternate Name:_____ Phone:_____

Preferred Doctor:_____ Phone:_____

Preferred Dentist:_____ Phone:_____

Insurance Company:_____ Phone:_____

2) Does your child have any of the following chronic conditions? (check all that apply)

_____ Allergies
_____ Arthritis/Rheumatic Disease
_____ Asthma
_____ Attention Deficit Disorder
_____ Birth Defects/Developmental Disorder
_____ Bleeding Disorders
_____ Heart/Vascular Disorders
_____ Connective Tissue Disorder
_____ Cystic Fibrosis
_____ Diabetes
_____ Eating Disorder
_____ Endocrine
_____ Gastrointestinal
_____ Genitourinary Disorders
_____ Hearing Problems
_____ Hypertension
_____ Immunosuppressive Conditions
_____ Malignancies
_____ Neurological Disorders
_____ Orthopedic Disorders
_____ Psychiatric Conditions
_____ Seizure Disorders
_____ Vision Deficit/Color Blindness
_____ Weight Disorder

Other:_____

If you checked any of the above, please explain:_____
_____ **(OVER)**

Name(s) of physician(s) treating the student for any of the above problem(s):

_____

Please list any medication(s) your child takes for any of the above conditions(s):_____

_____

Will it be necessary for your child to receive medication during school hours? _____

Please specify: _____

3) If your child requests any of the following medications, should the nurse dispense?

Tylenol (generic) ___ YES ___ NO If you checked yes, dosage: _____
Ibuprofen ___ YES ___ NO If you checked yes, dosage: _____
Antacid ___ YES ___ NO If you checked yes, dosage: _____
Benadryl ___ YES ___ NO
Throat Lozenge ___ YES ___ NO
Antibiotic ointment ___ YES ___ NO
Hydrocort Cream 0.5% ___ YES ___ NO

4) Please list any immunizations your child has had within the past year.

Immunization_____ Date _____ Immunization_____Date_____

5) Date of last physical_____ Last Tetanus booster_____

6) Parent Consent for Emergency Treatment

In the event that my child requires immediate emergency medical attention, I understand that the district will make every reasonable attempt to contact me or the alternates listed above.

In cases where this type of emergency treatment is required for my child, and parent, guardian, or alternate cannot be located, I give my permission for the district to obtain treatment from the closest medical facility, and will not hold the district or its professional staff responsible for any financial obligations incurred.

_____ _____

Signature of Parent or Guardian **Date**

In compliance with the Family Educational Rights and Privacy Act (FERPA),the information disclosed in this document may be shared with others who are responsible for the care and well being of your child.