



# Willard Elementary/Intermediate School

## HEALTH ROOM AND EMERGENCY INFORMATION

**\*\*Grade K-5<sup>th</sup> or New Student-Fill Form Out\*\***

**\*\*Grade 6<sup>th</sup>-Fill form out if not on file or ANY health changes have occurred\*\***

Dear Parent/Guardian-- Please **COMPLETE ENTIRE FORM**

Date: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Legal Name: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**\*\*Please Circle the correct answer:**

\*Does your child have a physician? YES or NO      \*Does your child have a dentist? YES or NO

\*In the case of an Emergency and we are unable to reach parent/ legal guardian, do we have permission to take your child to the closest Hospital or Physician?      YES or NO

\*Hospital Preference: \_\_\_\_\_

List of current Medications student is taking and reason:

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

**List any serious Illness, Injures, Health information, Medical problems- PLEASE CIRCLE IF APPLIES-**

examples include: Asthma, Diabetes, Seizures, Heart condition, Bone /Joint Problems, ADD, ADHD, mood or psychiatric disorders or any other health conditions. Please be sure to give the year the problem started or date of diagnosis: \_\_\_\_\_

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

**Please List any Allergies to food, medications, or other:** \_\_\_\_\_

**\*\*Per state law-If your child requires dietary accommodations at school, you MUST have a new form filled out by physician EACH school year. \*\***

Health screenings will be conducted in Elementary/Intermediate Schools. If you would not like your child to participate, please notify the appropriate nurse.

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

In the health room we have several over-the-counter medications. Here are a list of some of the things we might use: Tums, Peppermints, Oragel, anti-itch creams, anti-biotic ointment, cough drops, Benadryl, artificial tears, Afrin for nosebleeds, burn gel and sunscreen. I give permission for my student to be given the over the counter medication listed above.

**Signature of Parent/ Legal Guardian:** \_\_\_\_\_