WILLARD SCHOOL DISTRICT HEALTH ROOM INFORMATION FORM

*** To Be Completed By Parent Or Guardian ****

Student's Name: _____ Date:_____

Gender: Male ☐ Female ☐ Date of Birth: ____/____/____ Grade: _____

School Name:_____

Father's/Guardian's Name: _____Phone #: _____ Phone #:_____
Mother's/Guardian's Name: _____Phone #: _____Phone#:_____

Please place an "x" or check mark in the answers preceded by "Yes" or "No". Please include names of medications.

YES NO

☐ ☐ **ADD/ADHD**
Medication: _____

☐ ☐ **Anxiety**
Medication: _____

☐ ☐ **Autism/Asperger's**
Medication: _____

☐ ☐ **Asthma**
Medication:_____
(Please Attach Updated Asthma Action Plan)

☐ ☐ **Food Allergies**(Peanuts, Tree Nuts, Eggs, Milk, Food Dye,Etc).
Specify: _____

☐ ☐ **Vision Concerns** (glasses, contacts)

☐ ☐ **Headaches/Migraines**
Medication:_____

☐ ☐ **Orthopedic Issues** (assistive devices)
Specify_____

☐ ☐ **Diabetes** _____

☐ ☐ **Depression/Mental/Behavioral Illness**
Specify: _____
Medication: _____

YES NO

☐ ☐ **Stomach/Bowel Problems**
Medication:_____

☐ ☐ **Heart/Lung Problems**
Medication:_____

☐ ☐ **Kidney/Bladder Problem**
Medication:_____

☐ ☐ **Seizures**
Medication:_____
(Please Attach Updated Seizure Action Plan)

☐ ☐ **Hearing Concerns**
Appliances: _____

☐ ☐ **Cranial Shunt**_____

☐ ☐ **Allergies** (environmental, seasonal, animal dander, etc..)
Specify:_____

☐ ☐ **Allergic Reaction** (stings, medications, latex, etc)
Medication:_____

☐ ☐ **History of Concussion**
When?: _____

☐ ☐ **History of Cancer**
Specify: _____

☐ ☐ **Genetic Disorder**(Down Syndrome, CF, etc) _____

☐ **Other Health Concerns/Injuries**
Specify:_____

Other than what is listed above, is your child currently taking any medication on a regular basis? (Prescription or over the counter)

Medication:_____ Reason:_____
Medication:_____ Reason:_____

I understand if my child is injured or becomes seriously ill and the school nurse, principal, or designee cannot notify me by telephone, they will secure medical attention for my child and use ambulance services if necessary. I also understand that I will be responsible for the cost of such medical services and care.
Hospital Preference: _____

In 5th-12th grades, I give permission for my child to be given Ibuprofen/Tylenol if needed.

Parent's Signature: _____ **Date:** _____