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)*

❑Diabetes
❑Vision issues (❑Glasses ❑Contacts)
❑Heart problems
❑Physical handicap
❑ Asthma (breathing problems)
❑ Headaches/Migraines
❑ Hearing (Hearing Aids ❑Yes ❑No)
❑ADD/ADHD
❑Bleeding problems
❑Seizures or convulsions
❑Frequent nosebleeds
❑Urine/bowel problems
❑ **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 #: _____