HEALTH UPDATE INFORMATION FOR SCHOOL YEAR 20_____-20_____
WILLIAMS BAY SCHOOL DISTRICT

Student's Legal Name: ____
(Last) (First)
Date of Birth: __________/______________/_________________ Grade _________ Sex ______
(Month) (Day) (Year)

Does this student have a major medical condition? ______ NO ______ YES_____ If yes, indicate all that apply.

_____ ADD / ADHD (circle one) Medication Needed at school : Yes____ No_____
_____ Asthma: Uses Inhaler. if yes_____ Needs at school _________
_____ Allergies, please specify ____
Allergies requiring Epi-pen : Yes_______ No________
If yes, PROVIDED TO SCHOOL __________
_____ Bleeding Disorders
_____ Diabetes
_____ Heart Condition
_____ Medical Dietary Restrictions :Specify_______________________________________
_____ Seizures :Type___________________________________ Meds Required__________
_____ Other, please specify ____
.

Is this student currently receiving treatment for any of the above? _____ NO _____ YES

If "YES", please specify: ____

____.

List below the medications the student will take during school hours.
Please obtain the form *Prescription medication*, complete and return to the School Nurse or office.

MEDICATIONS): DOSAGE: TIME(S) ADMINISTERED:
1. ____
2. ____
3. ____

Booster vaccines of Tdap are required for 6th-12th graders. Date received : ______________________
Varicella #2 required K -5th grades: Date received: ________________
History of Chicken Pox. Date: ________________

Please specify any school-related limitations or special considerations required by the doctor.
____
____

Please specify any other relevant health information or concerns that you wish to make school personnel aware of:.____

Do you wish to meet with the school nurse to discuss an individual health plan for above noted health concerns?

Yes____ No___ Contact Information:____

(Parent's / Guardian Signature) (Date) ____