Woodland R-IV School District Health Services
Complete Health History

Name:	Birth Date:	☐ Male
Teacher:	Grade:	☐ Female

Doctor/Nurse Practitioner :	
Preferred Hospital:	

List Injuries:

_____

_____

List Surgeries:

_____

List any Special Procedures needed at school (catheter, dressing changes, etc.)

_____

_____

(In order for any of the above procedures to be done at school, the Nurse's office **must** have a signed doctor's order.)

Current Medications

Medication	Dosage	Frequency	Reason for Medication	Taken at School
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No

(In order for any of the above medications to be administered at school, the nurses must have the medication in the original bottle with prescription label attached and a completed medication administration form.)

Allergies/Allergic Reactions (Please see school nurse if you answer yes to any of these)

Food Allergy: Type	Yes / No	Reaction/Treatment:
Insect Allergy: Type	Yes / No	Reaction/Treatment:
Medication Allergy: Type	Yes / No	Reaction/Treatment:
Is EpiPen Required?	Yes / No	**If yes, YOU must provide an EpiPen for use at school.**
Seasonal Allergies	Yes / No	Reaction:

Asthma (Please see nurse if you answer yes)

Asthma: Yes / No	Triggers:
Medication Yes / No	Name/Dosage:

Diabetes (Please see nurse if you answer yes)

Diabetes Yes / No	Date Diagnosed:
Insulin Required Yes / No	Type/Dosage:
Medications Required Yes / No	Name(s)/Dosage:
Doctor Treating:	Name:

Seizure Disorder (Please see nurse if you answer yes)

Seizure Disorder	Yes / No	Description of seizures:
Medication	Yes / No	Name/Dosage:

ADD/ADHD

☐ ADD ☐ ADHD	Date Diagnosed:	
Medication(s)	Yes / No	Name/Dosage:

Eyes

Glasses/Contacts	Yes / No	For: ___ Reading ___ Distance ___ Difficulty Seeing
Lazy Eye	Yes / No	___ Right Eye ___ Left Eye
Concerns		___ Color Blind ___ Astigmatism ___ Strabismus
Surgery	Yes / No	Type/Date

Ears

Frequent Ear Infections	Yes / No	
Tubes Placed	Yes / No	Date inserted:
Hearing Device	Yes / No	___ Right Ear ___ Left Ear
Other Concerns:		

Other Health Concerns

___ Heart Problems ___ Lung Problems ___ Blood Disorders ___ Neurologic Disorders ___ Blood Pressure ___ Headaches/Migraines ___ Bladder/Bowel Problems ___ Skin ___ Orthopedic ___ Eating ___ Dental
Explain Condition(s):

My signature below verifies the above information to be accurate. I also permit the school nurse to share information with school staff as deemed appropriate/necessary by the nurses, to provide for my child's health and safety. In case of an emergency, the student may be transported by emergency medical services.

Signature of Parent/Guardian: _____ Date: _____