OCONOMOWOC AREA SCHOOL DISTRICT

School Health History Form
District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Dear Parent:

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it to your child's school when you register.

Child's Name _____ Sex _____ Birthdate _____

School Attending_____ Father's Name _____ Mother's Name _____

HEALTH HISTORY: **Please check (√) the following if applicable to this child:**

ADHD		Heart disorder	
Asthma		Hearing/Vision issue	
Autism		Mental health concern	
Bleeding disorders		Migraines	
Seizures		Musculoskeletal disorders	
Bowel/Bladder issue		Other (Fill in):	
Diabetes			
Food Allergies			

*Additional forms or health care plan may be required for some health conditions.

If you checked that your child has a health history, please explain. Also include any medical history that we should be aware of in the event of an emergency:

_____

_____

_____

_____

Does your child have allergies? ☐ Yes ☐ No If yes, to what? _____

Date of last reaction _____ What happened? _____Is an Epi-Pen prescribed for allergy? ☐ Yes ☐ No

*Additional Allergy Care Plan may be required.

MEDICATIONS

Is your child currently taking medication(s) at home? ☐ Yes ☐ No

Name of medication(s) _____

Do you anticipate your child will need to take medications at school?
☐ Yes ☐ No

Name of medication(s) _____
*Additional medication consent form will be required.

Is there anything more about your child that you think is important for us to know? ☐ Yes ☐ No If yes, please comment:

_____

_____

_____ _____
Parent Signature **Date**

_____ _____
District Nurse Signature **Date**