Request for Health Information **WRIGHTSTOWN COMMUNITY SCHOOL DISTRICT**

Must be Completed annually

School ____Date__________________________
Student's Name____________________________________ Date of Birth_______________________
Teacher____ Grade_________________________
Parent/Guardian (names) ____
Home Phone________________ Mom's work_____________ Mom's cell________________
Dad's work ______________Dad's cell__________________
Emergency Contact Person name and Phone ___________________________
Drug Allergy(s) None Known ____ Yes (list) ____
Treating Physician_______________________________________ Office Phone____________________

___ **MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS. (You may stop here if there are no known medical conditions. Please sign at the bottom and return.)**

Asthma Triggers: environmental __ seasonal __ exercise induced __ upper respiratory infection __ others ___________

Inhaler at school- MD order required. (If student will carry inhaler must have self- administration documented by parent and MD on medication form.)

Inhaler location: Carried by student _____ Health Room_____

Diabetes Type I __ Type II__ Diagnosis Date: __________ Insulin by: Pump ___ Injections ____
Desire Diabetes Care Plan: yes ___ No, independent with all care _____
Notify your school nurse and principal immediately if newly diagnosed

Food Allergy

Peanuts_____ Tree Nuts______ Milk_______ other(s)_____________
**Date/Type of Last Reaction________________ Student Needs for Class/School________________

Severe Sting Allergy

** Date and Type/Description of Last Reaction ____

****Notify your school nurse and principal immediately if anaphylaxis may occur****

Epilepsy Type(s) of Seizure(s): ____
Controlled with medication____ on medication, continues to have seizures_____
Diastat needed at school ______ No medication needed at school ______
Date and Type/description of last seizure ____

Other conditions/or specify pertinent data to help us better serve your child:

____

Does your child take routine medication(s) yes no List Meds: ______________________________
Does your child need medication(s) at school? yes no List Meds: _____________________________
If your child needs medication at school, a medication consent form is required to be signed by the health care provider and the parent/guardian.

***Medication cannot be given at the school until appropriate consents have been received. ***
****Wrightstown Community School District does not provide medications for students.****

As a parent you are responsible to inform the school of any significant medical condition updates during the school year. I give permission to the School Staff/School Nurse to share information regarding my child's medical condition(s) with my physician or emergency personnel and the school staff/teachers:

Date: __________________ Parent/Guardian Signature_______________________________________

Please contact the school if you have any questions.