Wrightstown Community School District

Student Health Services

District Nurse Olivia Koehn RN, BSN|(920) 532-0525 ext. 5016
Health Aide WES Erica Pivonka |(920) 532-4818 ext. 2010| Health Aide WMS Ashley La Roque|(920) 532-5553 ext. 4108
Elementary School Fax (920) 532-4664 |Middle School Fax (920) 532-3869 | High School Fax (920) 532-0860

New Student Health Information Form for School Year: _____

Student Name _____ Date of Birth _____

School Building _____ Teacher _____Grade _____

Parent/Guardian Name and Phone Number(s)_____

Parent/Guardian Name and Phone Number(s) _____

Emergency Contact Name and Phone Number(s) _____

Health History (circle any conditions your child has a history of and write in the age of your child at the time of the illness. Please also write CURRENT if a diagnosis is still currently a health issue for the student):

Asthma	Diabetes	Seizure Disorder
Allergies-food/nonfood items/insect bites/seasonal		Obesity/overweight/underweight
Skin Condition/Rash	Lupus	Anxiety/Depression
Heart failure/condition	Kidney Disease	Adrenal Hyperplasia
Phenylketonuria (PKU)	Bowel/bladder control issues	Anemia
Chicken Pox (Varicella)	Diphtheria	Strep Throat
Measles	Polio	Tonsillitis
German Measles (Rubella)	Hepatitis	Meningitis
Mumps	Frequent Stomach Aches	Hernia
Scarlet Fever	Pneumonia	Mononucleosis
Rheumatic Fever	Cancer	Frequent headaches
Whooping Cough (Pertussis)	Tuberculosis	Frequent ear infection
Fractures (Broken Bones)	Sexually Transmitted Infection	HIV/AIDs
Orthopedic (bone and muscle) issues	Arthritis	ADD/ADHD

Please write in any other missed condition in your child's health history or current health issues not included in the above list:

_____

Please write in any notes to clarify (for example what type of bowel/bladder problems or what type of congenital heart disease) or any other information of which the nursing services should be aware.

_____

Please list all medications your child is taking:

_____

Turn Over

Will skilled nursing services (tracheostomy, catheterization, etc.) be needed? If yes. please explain.

_____

Please list all surgeries/procedures your child has had:

_____

Will your child have any limitations to participation in classroom learning? If yes, please explain.

_____

Will your child have any limitations to participation in physical education/sports/ extracurricular activities? If yes, please explain.

_____

Does your child have a primary physician? Y or N How often does your child see this provider? _____

Name of provider: _____

Does your child see a dentist regularly? Y or N

Name of dentist:_____

Does your child wear glasses? Y or N **Does your child wear contact lenses? Y or N**

Does your child see an eye doctor regularly? Y or N

Name of eye doctor: _____

***Based on information gathered from this form additional forms may need to be filled out and will be dispersed to parent/guardian of student as necessary.**

Parent consent for management of health condition(s) while at school or other school-sponsored activities

I, the parent/guardian of the above-named student, grant permission and agree to:

1. Provide the necessary supplies and equipment, including medication in the original. pharmacy labelled container.
2. Authorize the administration of medication and treatment of health condition per any health plans.
3. Notify the school staff or school district nurse of any changes in the student's health status.
4. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
5. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition(s).
6. School staff interacting directly with my child may be informed about health condition(s).
7. Notify the school nurse of new health conditions and submit forms and health care plans if deemed necessary.
8. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
9. Hold without liability the Wrightstown Community School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of medication and treatment of health conditions, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the pertaining school year)

Date

School RN Signature _____ Date_____