Washington County School District Health Services

STUDENT MEDICAL HEALTH INFORMATION

Student:	Today's Date:
School:	Student Date of Birth:
Date of last physical exam:	Physician/Clinic:
Date of last eye exam:	Eye Examiner:

EMERGENCY CONTACTS

Mother:	Father:
Mother's Home Phone:	Father's Home Phone:
Mother's Work Phone:	Father's Work Phone:
Mother's Cell Phone:	Father's Cell Phone:
Other Emergency Contact and Phone:	

Parent/Guardian Consent and Agreement for Emergencies:
As parent/legal guardian, I give consent to have my child receive first aid by school staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs.

Date:_____ Parent/Legal Guardian:_____

HISTORY OF SPECIAL HEALTH CARE NEEDS

ADHD:
AUTISM:
ALLERGIES:
ASTHMA:
DEPRESSION/ANXIETY:
DIABETES:
DISABILITIES:
HEARING:
HEART:
MOBILITY:
SEIZURES:
URINARY:
VISION:
OTHER:

Is your child taking medication? ❑ Yes ❑ No Medication(s):_____

Is medication to be administered during school? ❑ Yes ❑ No (If yes, confer with staff for instructions.)

DATE	PROBLEMS / ASSESSMENTS / INTERVENTIONS / EVALUATIONS

FAX TO SCHOOL NURSE IF SPECIAL HEALTH CARE NEEDS EXIST * TO BE KEPT CONFIDENTIAL * FOR OFFICIAL USE ONLY