Ware Public Schools—Health Services

Health Information

Name_____ **Gr.** _____ **Teacher** (homeroom) _____

Date of Last Physical Exam _____ Physician's Name_____
Problems found _____ Town_____Phone (_____)_____

Date of Last Dental Exam _____ Dentist's Name_____
Problems found_____ Town_____Phone (____)_____

Date of Last Eye Exam _____ **Glasses / Contacts:** FULL TIME / DISTANCE / READING
(NOT school vision screening) (circle how glasses used)

Health Insurance _____ If student does not have ANY Health Insurance coverage, write: "NONE"
(NAME of insurance only)

Check ONE Column to RIGHT and COMMENT, if applicable

Health History (describe & note any medications currently used for this problem)	**Never**	**Past** (no concerns in 2+ years)	**Recent** (new concern in past year)	**Ongoing** (persistent over 1 year)
Allergic reactions **(specify below)				
Asthma				
Chickenpox				
Diabetes (type)				
Fainting				
Fractures / Dislocations / Sprains **(specify below)				
Frequent headaches/Migraines **(specify below)				
Heart Problems				
Kidney or urination problems				
Major Head / Neck / Back injury				
Psych / Emotional / Behavioral Concern **(specify below)				
Seasonal allergies				
Seizures *(please specify below)				
Skin problems **(specify below)				
Stomach / bowel problems **(specify below)				
Other (specify)				
**				
**				
**				

Seen by MD or in ER in past 3 months FOR URGENT OR EMERGENCY CARE? (reason / recommendations) _____

_____

Hospitalizations / Operations (explain) _____

Seen by a specialist? (specify reason and name of doctor) _____

What prescription medication(s) does he / she take at home? (reason ?) _____

_____
(If any medication must been taken during school hours, contact the School Nurse to arrange for a physician's order.)

Additional Comments _____

The School Nurse may communicate with other individuals (teachers, administration, physician, medical personnel) working with my child regarding his/her health. Any information will be given ONLY for the purpose of protecting or promoting health or providing appropriate educational services. The School Nurse may receive from my child's medical care provider any medical information necessary to provide school health services for my child.

Parent/Guardian signature _____ **Date** _____

TURN PAGE OVER AND COMPLETE STUDENT / CONTACT INFORMATION

Rev 6/2014