Wausau School District

Student Health Information

Name ______________________________ M/F Birth Date_______ Grade _____School _____________

The health information provided will be reviewed by the school nurse and confidentially shared with staff, as needed.

Please put a check mark if your child has any of the following conditions and give details under explanation.

√	Condition	Explanation
	Allergy (food,insect,drug, latex)	
	ADD/ADHD	
	Breathing problem/asthma	
	Bladder/bowel concern	
	Bleeding disorder	
	Bone/ joint/muscle condition	
	Cancer	
	Concussion/head injury	
	Diabetes	
	Diet/eating concern	
	Headaches	
	Heart condition	
	Immunity concern	
	Mental health concern	
	Seizures/epilepsy	
	Skin condition	
	Stomach/intestinal condition	
	Surgery	
	Vision/hearing concern	
	Other health concern	
	NO health concerns	

Medications: ____

Will any medications be taken at school? Yes/No If yes, have Medication Administration Consent form completed by MD.

Please list any other information about your child that would be helpful to staff working with your child.

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Parent/guardian signature: ______________________________ Relationship: ___________ Date: _________