

**WYLIE ISD HEALTH SERVICES
HEALTH HISTORY 2009-2010**

Please read and complete both sides.

All information will be confidential, except when needed to be shared with appropriate caregivers for your child.

Name of student	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Grade	Date of birth	Phone number
Address			City	Zip code
Mother/Stepmother/Guardian's name			Home phone number	Cell/Pager number
Place of employment			Work phone number	Email address
Father/Stepfather/Guardian's name			Home phone number	Cell/Pager number
Place of employment			Work phone number	Email address

BELOW PLEASE CHECK ALL ILLNESSES OR PROBLEMS AND EXPLAIN

MEDICAL PROBLEM	EXPLAIN	MEDICATIONS/TREATMENTS
<input type="checkbox"/> No Known Allergies		
<input type="checkbox"/> Allergic to medicine (list name of medication & symptoms of reaction)		
<input type="checkbox"/> Allergic to insect stings, foods, latex (list causes & symptoms of reaction)		EpiPen? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, see school nurse) <u>Additional medication:</u>
<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Asthma (An Asthma Action Plan is required for all students who are currently under treatment/care of a physician for asthma—See School Nurse for assistance)	Currently being treated/under physician care for asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Not being treated/under physician care, but having problems with asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Additional information:</u>	
<input type="checkbox"/> Behavioral or learning disorder		
<input type="checkbox"/> Blood disease		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Cerebral palsy		
<input type="checkbox"/> Cystic Fibrosis		
<input type="checkbox"/> Diabetes (A Diabetes Management & Treatment Plan is required for care at school—See School Nurse)	Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> <u>Additional information:</u>	
<input type="checkbox"/> GI (stomach/digestive tract) disease or problems		
<input type="checkbox"/> Heart disease or problems		
<input type="checkbox"/> Kidney disease or problems		
<input type="checkbox"/> Migraines		
<input type="checkbox"/> Muscular dystrophy		
<input type="checkbox"/> Neurological disorder		
<input type="checkbox"/> Orthopedic (bone) problems		
<input type="checkbox"/> Skin disorders		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Vision problems		<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
<input type="checkbox"/> Hearing problems		<input type="checkbox"/> Hearing aids <input type="checkbox"/> Implants
<input type="checkbox"/> Other		
<input type="checkbox"/> No Medical Problems		

Please list ALL medications your child is currently taking:

Medication	Dose/Time (s) given	Reason	Administration at school is needed?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

ALL MEDICATIONS ADMINISTERED AT SCHOOL REQUIRE A MEDICATION REQUEST FORM WHICH CAN BE OBTAINED FROM THE SCHOOL NURSE OR AT WWW.WYLIEISD.NET

HEALTH SERVICES INFORMATION
Please read and sign.

Please send all changes to contact information to the school office during the year.

Medication:

A. **Prescription medication** will be administered to a student if:

- the medication is provided by the parent or guardian
- the medication is in a prescription bottle from a pharmacy and includes the student's name, physician, instructions for administration, and is not expired.
- the parent supplies a written request for the medication to be given which includes:
 - Student's name
 - Name of the medication to be given and reason for giving
 - Date of permission and the number of days the medication is to be given
 - Time the medication is to be given, if applicable
 - Signature of the parent/guardian

B. **Over-the-counter medication** will be administered to a student if:

- the medication is provided by the parent, is in the manufacturer's packaging, is not expired, and is labeled with the student's first and last name
- the parent supplies a written request for the medication to be given (see Part A for note details)
- The medication is given for no more than 5 school days. After that, a note from the student's physician may be required for continued administration at school.

C. **Changes in medication** directions can be received by telephone by the prescribing provider, but must be confirmed in writing within 3 days of the change. Legible faxed orders will be accepted.

D. **Storage of medications** that are not taken daily throughout the year will be limited to a two week supply.

Signature of Parent

Print Name

Date