Wisconsin Heights School District Health Survey/Information
2021-22

This information must be updated annually to ensure our records are current.

Student Name: _____ DOB: _____ Grade: _____

YES ☑	NO ☑	
		Severe reaction to insect stings? Type: Reaction: ☐ Anaphylaxis ☐ Rash ☐ Hives ☐ Difficulty Breathing ☐ Swelling ☐ Cough ☐ Other_____ Treatment(s):
		Food allergies? If yes... Trigger(s): Reaction(s): ☐ Anaphylaxis ☐ Rash ☐ Hives ☐ Difficulty Breathing ☐ Swelling ☐ Cough ☐ Other_____ Treatment(s):
		Other allergies? If yes... Trigger(s): Reaction(s): ☐ Anaphylaxis ☐ Rash ☐ Hives ☐ Difficulty Breathing ☐ Swelling ☐ Cough ☐ Other_____ Treatment(s):
		***Epi-pen at Schoo**l: ☐ In school Health Office ☐ With Student (requires physician and parent's signature)
		Asthma? If yes, check one: ☐ Mild ☐ Moderate ☐ Severe Trigger: ☐ Exercise ☐ Illness ☐ Allergies Reaction:
		***Inhaler at School:** ☐ In school Health Office ☐ With Student (requires physician and parent signature)
		Heart Condition? If yes identify _____ Describe... Treatment(s): Restriction(s):
		Vision loss? (Not corrected by glasses) If yes, describe:
		Hearing loss? If yes, describe: Hearing Aid(s) ☐ Yes (L, R, Both) ☐ No
		Mental health? (i.e. ADD, ADHD, depression, anxiety) If yes, describe:
		Diabetes? If yes, describe action plan: (nurse will follow up with family about specific action plans)
		Seizures? If yes describe action plan: (nurse will follow up with family about specific action plans)
		Migraines / Headaches? If yes, describe: Treatment:
		Physical limitations? If yes, describe:
		Student takes medication at home? If yes, list medication(s):
		Student will take medication at school? If yes, list medication(s):
		Medication Name: Dose: Frequency: Taken at School: Y N
		Medication Name: Dose: Frequency: Taken at School: Y N

***Students who require prescription or over the counter medication during school hours must have a current medication consent form completed and signed by their parent/guardian and/or medical practitioner**.

This form must be submitted to the office **prior to** medication being administered or taken at school. Medication must come in the original container and be appropriately labeled. **Forms can be found on the district website or in the school office**.

Additional Pertinent Medical Information:

Release – In a medical emergency, I hereby authorize the school principal, nurse, or staff member to contact our physician or, if not available, an alternate physician, and to obtain emergency treatment for my child, if needed, if I or the other designated contact persons cannot be reached. If an ambulance is called, the costs are the responsibility of the parent/guardian. I give my permission to share this information with the appropriate school and medical personnel.

If you do not agree with this procedure, you must contact the school and file a Specialized Health Care Plan.

The parent/guardian signature below allows the school to share student health concern information with school staff members, bus drivers, and coaches/advisors that may come in contact with the student.

Signature:_____ **Date:**_____