FWCS
WE ARE YOUR SCHOOLS

HEALTH AND WELLNESS SERVICES

Personal Health History 2020-21

Student Name: _____ Gender: ____ DOB: _____ Gr: ____

Address: _____ City: _____ State: _____ Zip: _____

Notification Phone #1: _____ ☐ Emergency Only

Head of Household #1

Name: _____

Relationship to Student: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Notification Phone #2: _____ ☐ Emergency Only

Head of Household #2 (If applicable)

Name: _____

Relationship to Student: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

IN CASE OF ILLNESS OR EMERGENCY, FIRST CONTACT IS MADE TO THE PARENT(S)/GUARDIAN. Please list two contacts other than parents for emergencies.

Name: _____

Relationship to Student: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Name: _____

Relationship to Student: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Medical Information for School Personnel

☐**My child has no medical problems that affect the school day.**

For those with health conditions, please list any medication your child is currently taking.

Medication	**Dose**	**Time**

Is physical activity restricted? ☐**YES** ☐ **NO**

If yes, please explain:_____

_____

_____

_____

_____

Does the student have a 504? ☐ **YES** ☐ **NO**

Does the student have an IEP? ☐ **YES** ☐ **NO**

☐I believe my child's medical condition(s) substantially limits one or more of his/her major life activities.

Child's Primary Physician: _____

Physician's Phone Number: _____

Insurance ☐ Private ☐ Medicaid/HHW ☐ None

Has your child been hospitalized in the last year? ☐ **YES** ☐ **NO**

If yes, please explain: _____

_____

_____

_____

_____

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Please list any <u>severe life threatening</u> allergies that require medication

Please list specifics

☐ Food ☐ Needs Epi-pen _____

☐ Insect/Bees ☐ Needs Epi-pen _____

☐ Medications ☐ Needs Epi-pen _____

☐ Other ☐ Needs Epi-pen _____

<u>Please check the boxes if your child has any of the following issues</u>

☐ ADD/ADHD ☐ Head Injury/Concussion ☐ Lung Disease ☐ History TB ☐ Migraines with prescription medication

☐Psychological/Psychiatric

Describe: _____

☐Allergies non-life threatening

Describe: _____

☐ Asthma Has inhaler ☐ YES ☐ NO

☐ Autism ☐ Cystic Fibrosis ☐ Seizures ☐ Needs Diastat

☐ Sickle Cell ☐ Disease or ☐ Trait

☐ Cancer Type: _____

☐ Diabetes ☐ Type I ☐ Type II

☐Special procedures needed _____

☐ Other _____

Individual Health Plans should be in place for students with conditions like Asthma, Diabetes, Seizures and Severe Allergies. Some of these health plans require the signature of a physician. To insure the safety of your child, please contact your school nurse as soon as possible to complete these plans.

For internal use only

☐ Care plan sent to parent for completion Date _____

☐ Care plan returned to school Date _____

To ensure the care of my child, I read and agree that pertinent health information be provided to appropriate school staff. This will be done only on a 'need to know' basis, in a confidential manner. I agree that the school nurse may consult with my child's family physician(s) about the above medical condition(s). I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of the child. I will furnish the school with a current telephone number and address in case of an emergency. The above permission will be valid for one year from the date below, unless I revoke the permission in writing. In case of an emergency involving your child, it is the policy of this school cooperation to call a doctor, and only in extreme cases will your child be taken to the hospital.

Parent/Guardian Name _____ Date _____