Wausa Public Schools Student's Medical Information Form _____ 2019-2020

Student's Name – *Last* _____ *First* _____ *Grade* _____

Date of Birth -*Month* _____ *Day* _____ *Year* _____

Is your child receiving any services: SPED _____ 504 _____ SAT _____ Name of Case Manager _____

****Primary Care Physician:** _____

Does your child's medical history include any of the following:

Diagnosis or Treatment of Attention Deficit Disorders (ADD, ADHD) _____Doctor _____

Asthma _____ (please submit Asthma protocol from Doctor) Bowel or bladder problems _____

Chronic Ear Infection _____ Contacts _____ Freq. colds_____ Headaches_____ Hernia _____ History of Seizures _____

Orthopedic problems _____ Speech Defect _____ Wears Glasses _____

Any additional information: _____

_____

Allergies:
Bee/Wasp Sting Allergies _____ Food Allergies _____ list foods _____

Other Allergies_____

List any Physical Limitations _____

Has your child had any serious illness, operations or injury – please explain _____

Medication:
Is your child on any daily medications? _____

If so please list and name dosage and when administered: _____

_____

Does this medication need to be given at school?_____ When _____
If so please complete consent form in detail (form attached)
If your child requires medicine at school it must be in the <u>ORIGINAL PACKAGE</u> and accompanied by a signed permission slip from parent or guardian.

Permission:

I authorize the school and/or medical personnel to render necessary medical treatment to my child in an emergency

_____

Parent/Guardian Signature **Date**