



## Winston-Salem/Forsyth County Schools Student Health History and Emergency Medical information

Student's Name:	School:	
Parent, Guardian, Caretaker Name:	Grade:	Date of Birth:
Home Telephone:	Work Telephone:	

Please complete this brief health history form and return it to your child's teacher or school as soon as possible. This information is needed to care for your child in case of illness or injury and to meet your child's health needs at school. If your child needs medication at school, an **Administration of Medication Form** must be completed and returned to the teacher or school. The form can be obtained at school. Contact the school secretary if you need to talk with the school nurse.

The information contained on this form is confidential as provided by federal law, the Family Education Rights and Privacy Act, FERPA, 20 USC 1232g and state law. Only those school employees with a good educational reason may access and inspect this form. The school nurse has the right of access to this form. In a health related emergency, emergency personnel may be granted access to the information on this form.

### Where does the child receive health care:

Name of Doctor/Clinic:	Telephone:	Date of last physical exam:
Name of Dentist:	Telephone:	Date of last dental exam:

### Does your child have:

Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is your child allergic to:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when was last attack?	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your child need a diabetes care plan?	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when was last seizure?	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Problem <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child wear glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Does child have a hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does child wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name problem:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No Is exercise limited? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe problem:	
Other health problems. If yes, please describe:		

Was your child hospitalized or did your child have major changes in health within the past year?  Yes  No

If yes, please describe:


Signature of parent, guardian or caretaker:	Date:
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