Wrenshall School Annual Health History

Student Name:_____ Birthdate: ____/____/_____ Grade:_____

Parent/Guardian_____ Home Ph/Cell_____Work Ph_____

Current address: _____

Parent/Guardian_____ Home Ph/Cell_____ Work Ph_____

Current address: _____

Physician_____ Phone_____Dentist_____ Phone_____

Hospital Preference_____

In case of emergency/illness at school and parents can not be reached, call:

(1) Name _____ Relationship_____ Ph _____

(2) Name _____ Relationship_____ Ph _____

Immunizations are required by law to attend school.
Please provide documentation of all immunizations given in the past year.

Allergies:

_____

Current Health Diagnosis/Conditions (physical &/or mental health): (example: Asthma, Diabetes, ADHD)

_____

Serious illness, operation, hospitalization or accidents within the last 12 months:

_____

Medications (at home &/or at school) - provide drug name, dosage & time taken:

_____

When medication is to be taken in school: Contact the School Health Office.
Policy requires that a pharmacy labeled container of the medication be provided, along with written parent/guardian and prescriber permission. Medication forms are available from the school health office. The school is able to fax the provider for permission once parent/guardian signature is obtained.

Date of last eye exam: ____/____/____ By Dr: _____ **Glasses?** YES or NO **Contacts?** YES or NO

Reason for glasses: ___ Nearsighted ___ Farsighted ___ Other:_____

Date of last Physical exam: ____/____/____ By Dr:_____

Date of last Dental exam: ____/____/____ By DDS:_____

X_____ _____ _____
Parent/Guardian Signature Please print name Date