Student ID#_____

West Des Moines Community Schools
Student Health Summary
(To be completed by parent/guardian)

<u>This information is CONFIDENTIAL</u> but may be shared with appropriate school personnel when necessary.

Student's Name: _____Gender:___ Date of Birth: _____Grade/Team (if applies) in Fall: _____

Parent's Name(s): _____Daytime Ph #: H:_____ C: Mom_____ C: Dad_____

Please indicate (#1, #2, etc.) preferred order of notification in case of ill child W: Mom_____ W: Dad_____

In case of emergency, if parents cannot be reached, please contact: (These people have agreed to assume this responsibility)

Name: _____ Relationship: _____ Phone #:_____

Dr.'s Name _____Phone #: _____ Date of last physical_____ Immunizations this year_____

Should it become necessary, take my child to _____Hospital.

Health Concerns, Past and Present:

	Yes (√)	No (√)	Diagnosis/Explain		Yes (√)	No (√)	Diagnosis/Explain
Allergies: Environmental / BEE STINGS (**If yes**, see nurse for Action Plan)			**EPI-PEN _____ Benadryl_____**	Activity restrictions (Dr. Note required)			
Medication Allergies				Glasses/Contacts			
Food Allergies (if yes, see nurse for Action Plan)			**Food(s)_____ EPI-PEN_____**	Hearing/Speech Concerns			
Asthma/ Wheezing (**If yes**, see nurse for Asthma Questionnaire and Action Plan)			**Inhaler @ school?_____ Student to carry own inhaler?_____**	Seizure Disorder (**If** yes, Please see nurse for questionnaire/Action Plan)			**Type of seizures _____**
Diabetes (**If yes**, see nurse for Diabetes Mgmt Plan)				Headaches/Migraines			
ADHD				Kidney Disease			
Diagnosed with Anxiety / Depression				Head injury/ Concussions			
Heart Condition				Serious accident/Illness			

PLEASE LIST **MEDICATIONS** taken regularly **at home or school** and specify frequency, and reason for use.
Medications taken at school (OTC/ Prescription) need original labeled container/parent authorization forms completed.

_____

_____

Does your child have any emotional / behavior concerns or a medical diagnosis that may affect your child's learning?

_____

_____

I give permission to the School Nurse to give my child the appropriate dose of the following medications when needed: _____Ibuprofen (Advil/Motrin) _____Acetaminophen (Tylenol)
_____ Cough drops (provided by parent) _____Antacid tablets (Tums)

If as-needed pain reliever use is more than occasional, you will be asked to send in a personal supply for your child.

My child is covered by:
_____Private Health Insurance _____Title 19/Medicaid_____Hawk-I _____ No Health Insurance_____

If a medical emergency should arise, I agree to assume full financial responsibility for my child's medical care.
I understand I am responsible for updating this information as needed.

Parent Signature _____Date _____Start Date _____