WOODLAWN UNIT SCHOOL DISTRICT 209
STUDENT HEALTH INVENTORY

CHILD'S NAME: _____

BIRTHDATE: _____ GRADE _____

PARENTS' OR GUARDIANS' INFORMATION:

NAME _____

RELATIONSHIP TO CHILD _____

ADDRESS _____

HOME PHONE _____ CELLULAR _____

WORK PHONE _____

NAME OF RESPONSIBLE ADULT WHO WILL ASSUME RESPONSIBILITY FOR THE STUDENT IF PARENT/LEGAL GUARDIAN CANNOT BE REACHED.

NAME _____ TELEPHONE _____

NAME _____ TELEPHONE _____

PHYSICIAN'S NAME _____ TELEPHONE _____

DENTIST'S NAME _____ TELEPHONE _____

CLINIC OR HOSPITAL _____ TELEPHONE _____

DOES THE STUDENT HAVE:

ALLERGIES? YES____NO____ PLEASE LIST _____ EMERGENCY ACTION REQUIRED? YES____NO____

IF SO WHAT ACTION: _____

BEE STING ALLERGY? YES____NO____ EMERGENCY MEDICATION NEEDED YES____NO____

ASTHMA? YES____NO____ TRIGGERS:_____TREATMENT: _____

DIABETES? YES____NO____TAKES INSULIN? YES____NO____

SEIZURES/EPILEPSY? YES____NO____TYPE OF SEIZURE:_____DATE OF LAST SEIZURE:_____

HEART CONDITION? YES____NO____ ANY PHYSICAL RESTRICTIONS? _____

BONE/JOINT PROBLEMS? YES____NO____ANY PHYSICAL RESTRICTIONS? _____

VISION PROBLEMS? GLASSES: YES____NO____ CONTACTS: YES____NO____ LAST EYE EXAM: _____

HEARING PROBLEMS: FREQUENT EAR INFECTIONS? YES____NO____ TUBES? YES____NO____

OTHER HEALTH INFORMATION OR CONCERNS: _____

_____

CURRENT MEDICATIONS: _____

I HEREBY RELEASE THE SCHOOL NURSE OR EMPLOYEE OF WOODLAWN UNIT SCHOOL DISTRICT 209 TO CONTACT THE ABOVE LISTED PHYSICIAN OR YOUR FAMILY MEDICAL FACILITY, JEFFERSON COUNTY HEALTH DEPARTMENT BY PHONE, FAX OR MAIL REGARDING MY CHILD, FOR THE PURPOSE OF PROVIDING INFORMATION (IMMUNIZATIONS RECORDS, SCHOOL HEALTH EXAMINATIONS, MEDICATION, OR TREATMENTS) MEDICALLY NECESSARY FOR MY CHILD'S WELL BEING AT SCHOOL. IN THE EVENT A PARENT CANNOT BE CONTACTED THIS RELEASE GIVES WOODLAWN UNIT SCHOOL DISTRICT 209 THE PERMISSION TO SEEK MEDICAL ATTENTION AND TRANSPORT YOUR CHILD IN CASE OF AN EMERGENCY.

SIGNATURE: _____DATE: _____