

Plymouth Joint School District - HEALTH INFORMATION

STUDENT NAME: _____ DOB: _____ GRADE: _____ GRAD. YR: _____

Please complete and sign below even if no health conditions exist.
 Every effort will be made to protect the confidentiality of student health information.

<p>ALLERGIES <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Food _____</p> <p><input type="checkbox"/> Insect _____</p> <p><input type="checkbox"/> Seasonal _____</p> <p><input type="checkbox"/> Other _____</p>	<p>Can the allergy cause a severe reaction or anaphylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete an <i>Allergy Health Action Plan*</i>)</p> <p>Does your child require emergency epinephrine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does your child require an oral antihistamine? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete a <i>Medication Authorization Form*</i>)</p>
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<p>HAS YOUR CHILD BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS? <input type="checkbox"/> NONE</p>	
<p><input type="checkbox"/> ADD/ ADHD _____</p> <p><input type="checkbox"/> Asthma (complete <i>Asthma Health Action Plan*</i>) _____</p> <p><input type="checkbox"/> Bladder/ Bowel Issues _____</p> <p><input type="checkbox"/> Diabetes (school nurse will contact you) _____</p> <p><input type="checkbox"/> Dietary Restrictions _____</p> <p><input type="checkbox"/> Emotional/ Behavioral / Mental health _____</p> <p><input type="checkbox"/> Epilepsy/ Seizures (complete <i>Seizure Health Action Plan*</i>) _____</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Head injury/Concussion Hx _____</p> <p><input type="checkbox"/> Headaches/ Migraines _____</p> <p><input type="checkbox"/> Hearing Loss/ Hearing aide _____</p> <p><input type="checkbox"/> Heart Condition/ Bleeding Disorder _____</p> <p><input type="checkbox"/> Orthopedic _____</p> <p><input type="checkbox"/> Recent Surgeries _____</p> <p><input type="checkbox"/> Vision: Glasses/ Contacts/ Other _____</p>

<p>MEDICATION: Is your child currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<u>Medication name:</u>	<u>For condition:</u>	<u>How often:</u>	<u>Taken at school?</u>
<p>If medication must be given at school, a <i>Medication Authorization Form*</i> is required.</p>			

Wisconsin State Immunization Law *requires* all schools to have each student’s immunization record showing the student has met all immunization requirements. It is the parent’s responsibility to provide this record or sign an immunization waiver. Parents will be notified if the school does not have a complete record.

6th grade only – Students entering 6th grade need a Tdap (tetanus/diphtheria/pertussis) immunization. **Tdap date:** _____

*All health forms can be found on the Plymouth School District website or by contacting your school office. Visit www.plymouth.k12.wi.us, **Student & Family/ Health Services**, for health information and forms.

Contact one of the District School Nurses if you have any health questions or concerns at 892-2661, Ext. 4136 (Elementary Schools), Ext. 2105 (Middle school) or Ext. 1047 (High School).

Parent / Guardian Signature

Date