



**West Marshall Community Schools
Health Information Form**



Student Name: _____

Please provide the following documents to your school's health office:

Physical Exam	Dental Exam	Vision Exam
Counseling	Lead Level Results	Hospitalization
Emergency Room Visit		

Has your child been diagnosed with any of the following medical or health concerns?

Please mark all that apply

Diabetes	Migraines	Cardiac (Heart) concerns
Frequent Ear Infections	Seizures	Asthma/Other Lung concerns
Bowel Concerns	Head Injury	Kidney/Bladder concerns
ADD/ODD/ADHD/etc	Depression	Other (please describe below)

Please Describe any health problems you marked about and list any other medical concerns your child may have: _____

List any current or daily medications: _____

Do any of these medications need to be administered at school? If yes please complete medication administration form.

Please check which medications your child may receive for minor health problems that include but not limited to: *colds, menstrual cramps, headache, sore throat, eye irritations, minor burns, sprained ankle, nasal congestion, upset stomach, rashes.*

(These medications would only be given as needed and according to label directions. Parent will be contacted if medication is administered.)

<input type="checkbox"/> Anbesol/Orajel	<input type="checkbox"/> Acetaminophen/Tylenol	<input type="checkbox"/> Tums (age 12 & up)
<input type="checkbox"/> Advil/Ibuprofen/Motrin	<input type="checkbox"/> Triple Antibiotic Ointment	<input type="checkbox"/> Cough Drops
<input type="checkbox"/> Benadryl: Cream/oral	<input type="checkbox"/> Bacitracin Ointment	<input type="checkbox"/> Hydrocortisone Cream

Does your child have any Food Allergies, Environmental Allergies, or Medication Allergies?

☐ Yes ☐ No **If yes please list allergen and response:**

Does your child have an Epi Pen to use due to an anaphylactic allergic response? ☐ Yes ☐ No

If yes please provide an epi pen to the school with box that includes prescription information on it. Also, please complete an allergy emergency response form.

Health information may be shared with school personnel? ☐ Yes ☐ No

Does your child have health insurance? ☐ Yes ☐ No

Would you like information regarding Hawk-i Insurance? ☐ Yes ☐ No

Should your child need medical attention and we cannot reach you, do you authorize school personnel to get medical attention from the local clinic? ☐ Yes ☐ No

Parent/Guardian Signature: _____ **Date:** _____