WILLS POINT INDEPENDENT SCHOOL DISTRICT

**STUDENT HEALTH INFORMATION AND EMERGENCY AUTHORIZATION**

School Year _2016 – 2017_

☐ **New** ☐ **Returning**

Student's Name ______________________________ (M) (F) Birthdate ____________ Grade ________
(Last, First, Middle)

Student's Address ______________________________ City ______________ Zip Code ________

Student Driver License # ______________________ Student Cell Phone ______________________

Student lives with ☐ both parents ☐ mother ☐ father ☐ other ______________________ ______________________
Name/relationship to Student Who is the student's legal guardian?

**In case of student emergency, illness, or accident, the school is authorized to contact one of the following people. We will always attempt to contact the parent or guardian first.**

Father/Stepfather/Guardian ______________________ Phone (home) ____________ (cell) ____________
Employed by: ______________________ Phone (work) ____________ Email ______________________

Mother/Stepmother/Guardian ______________________ Phone (home) ____________ (cell)____________
Employed by: ______________________ Phone (work) ____________ Email ______________________

(1) Name ______________________ Relationship ______________________ Daytime Phone ______________
(2) Name ______________________ Relationship ______________________ Daytime Phone ______________
(3) Name ______________________ Relationship ______________________ Daytime Phone ______________

List any brothers/sisters in WPISD schools______________________ ______________________ ______________________
(Name and Campus) (Name and Campus) (Name and Campus)

**IF THE ABOVE NAMED PERSONS CANNOT BE CONTACTED AND THERE IS AN EMERGENCY REQUIRING IMMEDIATE MEDICAL ATTENTION WPISD IS AUTHORIZED TO INITIATE THE 911 SYSTEM. I UNDERSTAND THAT WPISD DOES NOT ASSUME FINANCIAL RESPONSIBILITY FOR ACCIDENT OR ILLNESS THAT OCCURS AT SCHOOL.**

______________________ ______________________ ______________________
*Parent/Guardian Signature (with custody) Driver License # Date

______________________ ______________________ ______________________
*Parent/Guardian Signature (Parent #2) Driver License # Date

## MEDICAL HISTORY

1. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No (If no, go to question #2.)

☐ Yes (If yes, explain why and when below.)

| **My child was in the hospital because:** | **When** |
|---|---|
| **Example:**<br>Bike accident-concussion | 5 years old |
| | |
| | |

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2. Is your child taking any **prescription medicines**?

☐ Yes - Please list the child's medicines below OR

☐ No. My child does not take any prescription medicines. (If no, go to question #3)

☐ Yes ☐ No. Does your child use an inhaler or breathing treatments? If YES, please list medicine below.

| **Name of medicine** | **Amount / size of pill** | **How many pills or doses does your child take at** |
|---|---|---|
| **Example:**<br>Dexadrine | 10 mg | _1_morning _1_noon ____dinner ____bed |
| | | ____morning ____noon ____dinner ____bed |
| | | ____morning ____noon ____dinner ____bed |
| | | ____morning ____noon ____dinner ____bed |

3. What **over-the-counter medicines** does your child take **regularly**?

☐ Vitamins

☐ Herbal medicine (please list) ________________________________________

☐ Other medicines like Tylenol, Advil or something else? (Please list)________________________

________________________________________________________________

☐ **None**, my child does not take any over-the-counter medicines regularly.

****If you want your child to have Tylenol, Motrin, Advil, ect., you have to provide a doctor's note and the medication.***

4. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)

☐ Outside or Indoor allergies, (*for example: hayfever, grass, pollen, cats* …) **Please list below ↓**

☐ Food Allergies (*for example: peanuts, milk, wheat …)* **Please list below ↓**

☐ Insect or Animal Allergies (*for example: bees, wasps, cats…)* **Please list below ↓**

☐ Medicine or shots (*immunization*). **Please list below ↓**

☐ **No**, my child has no allergies that I know of.

Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

| **My child is allergic to:** | **What happens when your child has a reaction?** |
|---|---|
| **Example:**<br>amoxicillin | Diarrhea (runny poop) |
| | |
| | |
| | |

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5. Has your child had any of the following **medical problems or injuries**? (examples in parenthesis)
Describe **your child's** problem for each ☒**Yes** on the lines at the bottom of the page ↓ .

| | |
|---|---|
| **Chicken Pox--**Date if had chickenpox: | ☐ Yes ☐ No |
| **Surgery --**Date of any surgeries: | ☐ Yes ☐ No |
| **Head Injury** or **Concussion** | ☐ Yes ☐ No |
| **Ear** infections *(often has them, ear tubes, etc)* | ☐ Yes ☐ No |
| **Nose** problems *(sinus infections, nose bleeds)* | ☐ Yes ☐ No |
| **Eye** problems *(blurry vision, wears glasses, lazy eye)* | ☐ Yes ☐ No |
| **----**Should **wear glasses or contacts** to see ☐ far away ☐ read | |
| **Hearing** problems *(has trouble sometimes, wears hearing aid)* | ☐ Yes ☐ No |
| **Mouth or throat** problems *(Strep throat, swallowing problems)* | ☐ Yes ☐ No |
| **Constipation** *(problems having a bowel movement (BM))* | ☐ Yes ☐ No |
| Problems **peeing** *(bed wetting, pain when peeing)* | ☐ Yes ☐ No |
| **Back** problems *(crooked back, back pain)* | ☐ Yes ☐ No |
| **Muscle and bone** problems *(weak muscles, pain in joints)* | ☐ Yes ☐ No |
| **Skin** problems *(acne, flaking skin, rashes, hives)* | ☐ Yes ☐ No |
| **Seizures** *(shaking fits or convulsions)* | ☐ Yes ☐ No |
| **ADD/ADHD** *(problems paying attention, sitting still)* | ☐ Yes ☐ No |
| **Breathing** problems *(cough, asthma)* | ☐ Yes ☐ No |
| **Heart** problems *(fast or irregular heart beat, murmur, birth defect)* | ☐ Yes ☐ No |
| **Feelings or emotions** *(depression, anxiety, fears)* | ☐ Yes ☐ No |
| **Other:** | ☐ Yes ☐ No |

Did you ☒**Yes** for any problems above? **Tell us more here:**__________________________________________
__________________________________________________________________________________

____________________________________________________ ____________________
Signature of person filling out form Date filled out

** Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*

Doctor ________________________________________________ Dentist ______________________________________________
Name and phone # of student's doctor Name and phone # of student's dentist

I grant permission for my child's physician to report his/her findings to authorized personnel of WPISD. This medical information may be shared with authorized personnel of WPISD on a need-to-know basis. I agree to notify the school of any changes to the information listed above.

Signed ____________________________________ Relationship to Child ________________________ Date __________________

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