Wahkiakum School District #200

School Health Inventory

500 South Third Street/ **PO** Box 398
Cathlamet, WA 98612

Student _____ DOB _____ Sex _____ Grade _____

Regular Physician or Clinic (if any) _____ Preferred Hospital _____

Mother's/Guardian's Name _____ Work Place _____ Ph. # _____
Phone #

Father's/Guardian's Name _____ Work Place_____Ph. # _____

Mailing Address _____ Home Phone #_____ Emerg. #_____

City & Zip Code _____ Student Lives With _____
Relationship

DOES YOUR CHILD HAVE A HISTORY OF:

Allergies No ❑ Yes ❑ ❑ Life Threatening Specify _____

Anorexia	No ❑	Yes ❑	Specify _____
Asthma	No ❑	Yes ❑	Specify _____
Blood Disorders	No ❑	Yes ❑	Specify _____
Cancer	No ❑	Yes ❑	Specify _____
Depression	No ❑	Yes ❑	Specify _____
Diabetes	No ❑	Yes ❑	Takes Insulin No ❑ Yes ❑
Ear Infections	No ❑	Yes ❑	Date of Last Infection _____
Epilepsy or Seizures	No ❑	Yes ❑	Date of Last Seizure _____
Heart Condition	No ❑	Yes ❑	Specify _____
Insect/Bee Sting Allergies	No ❑	Yes ❑	Reaction Local ❑ Systemic ❑
Kidney Disease	No ❑	Yes ❑	Specify _____
Migraines	No ❑	Yes ❑	Specify _____
Orthopedic Problems	No ❑	Yes ❑	Specify _____
Headaches	No ❑	Yes ❑	Specify _____
Nervousness or Emotional Trauma	No ❑	Yes ❑	Specify _____
ADD or ADHD	No ❑	Yes ❑	Specify _____

HAS YOUR CHILD HAD?

Serious Illness	No ❑	Yes ❑	Specify _____
Serious Injury	No ❑	Yes ❑	Specify _____
Surgery (Operations)	No ❑	Yes ❑	Specify _____

CONTINUED FROM OTHER SIDE

DOES YOUR CHILD HAVE			DOES YOUR CHILD?		
Trouble Seeing Close Work	No ❑	Yes ❑	Wear Glasses	No ❑	Yes ❑
Trouble Seeing At A Distance	No ❑	Yes ❑	Wear Contacts	No ❑	Yes ❑
Trouble Hearing	No ❑	Yes ❑	Wear Hearing Aids	No ❑	Yes ❑

Does your child have a condition which prevents participation in regular Physical Education (running, push-ups, wrestling, contact sports, etc? No ❑ Yes ❑

Specify _____

Does he or she take daily medication? No ❑ Yes ❑

Specify _____

Does your child need to have any medical or physical restrictions? No ❑ Yes ❑

Specify _____

Does your child require any specific medical equipment/Medical or nursing procedures at school?

No ❑ Yes ❑ Specify _____

STATE AND SCHOOL DISTRICT REGULATIONS REQUIRE PHYSICIAN and PARENT PERMISSION FOR TAKING MEDICATION AT SCHOOL. Please obtain this permission form from the school office or health room and/or ask your physician to fill one out and sign it before leaving the Dr. office.

SIGNATURE OF PARENT OR GUARDIAN _____

Signature Date of Signature

IN THE EVENT OF AND EMERGENCY, Of THE PARENT AND OR AUTHORIZED PHYSICIAN NAMED ON THIS INVENTORY cannot be reached at the time of the emergency and immediate observation or treatment is needed in the judgment of school authorities and/or emergency medical services) I AUTHORIZE AND DIRECT THE SCHOOL AUTHORITIES TO SEND THE PUPIL *(properly accompanied)* TO THE HOSPITAL OR PHYSICIAN MOST EASILY ACCESSIBLE.

I understand that I. will assume full responsibility for the payment of any services rendered.

Insurance Yes ❑ No ❑ if *Yes* Who Is Your Carrier: _____

May the student receive blood products in an EMERGENCY? No ❑ Yes ❑

Signature of Parent/Guardian _____

Signature Date of Signature