WESTMINSTER SCHOOLS OF AUGUSTA

School Year: 2020-21

Grade Entering: _____

# STUDENT HEALTH HISTORY

Student's Name: Last _____, First _____ MI _____

Prefers to be called: _____ Birthdate: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Mother's Name: _____ Cell Ph: _____ Wk Ph: _____

Father's Name: _____ Cell Ph: _____ Wk Ph: _____

Home Ph: _____ Date of Last Physical: _____

Emergency Names/Numbers (if you cannot be reached): _____

_____

List any health concerns or conditions that your child has now or has had in the past (be specific): _____

_____

_____

Has your child ever been hospitalized or required surgery? _____ If so, please explain with details, dates, and age(s) if possible:

_____

_____

## HEALTH CHALLENGES

Please check all that apply and include any pertinent details including successful treatments/medications (be as specific as possible):

___ ADD/ADHD – Diagnosed at age: _____

___ Asthma or other Respiratory Condition _____

___ Ear, Nose, Throat Conditions _____

___ Heart Conditions _____

___ High/Low Blood Pressure _____

___ GI or Digestive Conditions (constipation or IBS, frequent stomach aches) – explain _____

___ Seizure Disorder _____

___ Other Neurological Conditions (i.e., history of concussions) _____

___ Frequent Headaches or Migraines – specify _____

___ Diabetes _____

___ Other Endocrine (hormone) Disorders _____

___ Orthopedic (bone/joint/spine) Disorders _____

___ Hearing or Vision Impairment _____

___ Wears Glasses/Contacts _____

___ Anxiety or Depression _____

___ Other Emotional Conditions or Concerns _____

___ Appendectomy or Tonsillectomy (date/age) _____

___ Immune System Disorders _____

___ Blood Disorders (i.e., hemophilis, sickle cell) _____

___ Bedwetting _____

___ Dysmenorrhea (difficult periods) _____

___ Eating Disorder _____

***Please fill out both sides of this form.***

2020-21

Student's Name: _____

## ALLERGIES

Please check all that apply and include any pertinent details including successful treatments/medications (be as specific as possible):

___ Medication Allergies _____

_____

___ Food Allergies _____

_____

___ Other Allergies (environmental, animals, etc.) _____

_____

Please Note: Emergency medications (such as EpiPens, inhalers, insulin, etc.) may be carried by the student and self-administered only when certain conditions are met. Please see the school nurse if your child requires such medication.

## PERMISSION TO ADMINISTER MEDICATION - *I give Westminster permission to administer the following*:

__Yes __No Acetaminophen (Tylenol)

__Yes __No Ibuprofen (Advil, Motrin, etc.)

__Yes __No Antacid (Tums, Maalox, etc.)

__Yes __No Diphenhydramine (Benadryl)

__Yes __No After Bite (insect bite swab)

__Yes __No Hydrocortisone Cream (bug bits, rashes, etc.)

__Yes __No Cough Drops

__Yes __No Triple Antibiotic Ointment (Neosporin, etc.)

__Yes __No Hydrogen Peroxide (to clean cuts, abrasions, etc.)

*Dosage will be determined by school nurse according to PDR and physicians guidelines, unless otherwise specified by parent.*

## PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES

PRESCRIPTION:

| Name of Medication | Dosage | Time(s) Taken | Purpose |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

NON-PRESCRIPTION:

| Name of Medication | Dosage | Time(s) Taken | Purpose |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Please be sure to read the WSA Clinic Policies in your handbook regarding:

- Medications at school
- When to keep your child at home
- Procedures for informing the school when parents leave town

If your child is evaluated by the school nurse, faculty or staff for illness, injury, or another type of health concern and requires treatment, your permission is required. By signing below, you give the school nurse, faculty, or staff permission to assist your child medically.

Parent Signature _____ Date _____

## School Counselor *(initial one of the options below)*

_____ I give permission and I attest that I have legal right to grant permission for my child to see the school counselor. I understand that what my child says in counseling is confidential, within the laws of counseling confidentiality. I give the counselor permission to give my child's teacher general feedback about issues or plans that could help the teacher serve my child better. I understand that the counselor will not give the teacher direct information about what my child discusses with her; she will only give the teacher suggestions about helping my child.

_____ I do not want my child/children to see the counselor individually. However, I understand that the counselor may work with my child's classroom as a whole or with a group of children at the teacher or principal's request. Also, if an emergency arises, my child may be asked to see the counselor for one session regarding that emergency.