



# Willamette Kids PRESCHOOL

MYWILLAMETTE.COM/PRESCHOOL



## STUDENT HEALTH FORM

Today's Date: \_\_\_\_\_

This information will enable us to be aware of any health-related concerns or emergencies that may arise. This is kept confidential in your child's cumulative health folder for professional use only.

Student's Full Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Medical Treatment Release

In the event of an emergency and I am unavailable, I authorize school personnel to make arrangements for my child to receive medical care, including required transportation in an ambulance to the nearest hospital or treatment facility. I authorize the physician and/or dentist named below to undertake such care as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician and surgeon. I agree to bear all costs incurred.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

May Tylenol or Advil (or equivalent brand) be given to the student if needed?  Yes  No Please Initial: \_\_\_\_\_

### Medical Service Information

Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information:

Does your student have medical insurance coverage?  Yes  No

Insurance Company: \_\_\_\_\_ Membership No. \_\_\_\_\_ Group No. \_\_\_\_\_

Primary Insured: \_\_\_\_\_ Primary Insured's Membership No. \_\_\_\_\_

Does your student have dental insurance coverage?  Yes  No

Insurance Company: \_\_\_\_\_ Membership No. \_\_\_\_\_ Group No. \_\_\_\_\_

Primary Insured: \_\_\_\_\_ Primary Insured's Membership No. \_\_\_\_\_

\*\*In the event of emergency transport, your student will be taken to River Bend Hospital in Springfield, OR unless otherwise directed by emergency personnel.

### General Information

#### Current medications taken (list both prescription & nonprescription medications including vitamins/herbs):

Drug name \_\_\_\_\_ Dose \_\_\_\_\_ Administered at school?  Yes  No

Drug name \_\_\_\_\_ Dose \_\_\_\_\_ Administered at school?  Yes  No

Drug name \_\_\_\_\_ Dose \_\_\_\_\_ Administered at school?  Yes  No

Drug name \_\_\_\_\_ Dose \_\_\_\_\_ Administered at school?  Yes  No



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## STUDENT HEALTH FORM (Page 2)

Does your student:

- |                           |  |  |  |                                   |  |
|---------------------------|--|--|--|-----------------------------------|--|
| <b>Wear glasses?</b>      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Contacts?</b>                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| <b>Have hearing loss?</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Use hearing aids?</b>                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| <b>Have a history of:</b> | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Condition |

Please enter date or age of occurrence or diagnosis for the following:

Chicken Pox \_\_\_\_\_ Neurological Problems \_\_\_\_\_ TB Contact \_\_\_\_\_  
Orthopedic Problems \_\_\_\_\_ Serious Injury \_\_\_\_\_ Frequent headaches \_\_\_\_\_

Does your student have any allergies? If none, write "none". Please be specific, attach additional sheets as needed.

Are there any medical conditions that would limit your child's normal school activities? Yes No

If yes, explain:

### Emotional/Psychological Information

Has your student experienced a recent significant loss of a loved one or other emotional distress? Yes No  
(Loss of grandparent, pet, divorce, etc.)

If so, please explain:

Is your student currently under the care of a child psychologist/counselor? Yes No If so, please explain.

Does your student have problems with temper tantrums or emotional outburst? Yes No

Does your student show signs of hyperactivity or attention difficulties? Yes No

Has your student been diagnosed with an attention deficit disorder? Yes No ADD ADHD

Has your student been diagnosed with a sensory integration disorder? Yes No SPD Autism PDD

### Other

Please note any additional comments or concerns you would like us to know about your student's health. If you need more space, feel free to add another page.