WAUSAU SCHOOL DISTRICT

Student Health Information

Name:_____ **M/F**_____ **D.O.B.:**_____ **Grade:**_____ **School:** _____

The health information provided will be confidentially shared with staff to assist in educational planning. Please complete this form.

Please indicate if your child has any of the following conditions:

IF "YES," PLEASE EXPLAIN	Age Diagnosed	EXPLANATION
ADD/ADHD		
Bone/Joint/Muscle Condition		
Heart or Blood Condition		
Vision or Hearing Concerns		
Digestive or Dietary Concerns		
Cancer/Leukemia		
Skin Condition		
Diabetes		
Epilepsy/Seizure Rescue medication needed?		
Respiratory Condition Rescue Medication needed?		
Allergy(environment,food,animals,medication, etc) Rescue medication needed?		
Activity Limitations/ Ambulatory needs		
Medication to be taken at school?		

Please note any other health concerns that you feel would be helpful for the school to know:

_____

_____

_____

School Nurse Contact Information can be received by calling Sheryl Kazda at 715-261-0570

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