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.

Is your child's general health good? YES ☐ NO ☐

Does your child currently have:

CHECK EACH ITEM IF "YES," PLEASE EXPLAIN	YES	NO	EXPLANATION
Asthma			
Attention Deficit Disorder			
Bone/Joint/Muscle Disorder			
Diabetes			
Eye glasses/Contacts			
Gastrointestinal Disorder			
Hearing Aid – left/right			
Heart Disorder			
Migraines			
Seizure Disorder			
Does your child have a physical disability?			
Does your child's physical activity need to be limited?			
Does your child have an allergy?			To what? Symptoms?
Does your child take medication at school?			

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

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Date: _______________ **Parent/Guardian Signature:** ______________________________

C-99
Nurses//policy student Health Information
Revised: March 1996 and April, 2001