Wayland Public Schools
Student Health History

Name_____ Date of Birth ___/___/___ Sex:_____
Address_____
Parent/Guardian Name_____Occupation_____D.O.B_____
Tel# _____ Cell#_____Email_____
Parent/Guardian Name_____Occupation_____D.O.B_____
Tel# _____ Cell#_____Email_____

Student's Primary Care Physician:_____Phone#_____Address:_____

STUDENT'S MEDICAL HISTORY

Illness	**Age**	**Illness**	**Age**	**Illness**	**Age**	**Illness**	**Age**	**Illness**	**Age**
ADD/ADHD		Cancer		Fainting Spells		Heart Condition		Rheumatic Fever	
Asthma		Concussion		Foot Disorder		Kidney Disorder		Thyroid Condition	
Bone Condition		Diabetes		Frequent Ear infections		Nosebleeds		Strep Throat	
Bladder/ Bowel Condition		Epilepsy/ Seizure Disorder		Frequent Headache		More than 3-4 Colds per year		Speech Condition	

Developmental/Medical/Social/ or Family health conditions that the Nurse should be aware of? Yes___ No___
If yes, please explain_____

Has the student ever had a serious Accident, Surgery, or been Hospitalized? Yes_____ No_____
If yes, please explain_____

Has the student had trouble with Hearing? Yes___ No___ If yes, please explain_____
Name and Address of Ear Doctor_____

Has the student had trouble with their Eyes crossing/turning in? Yes__ No__ Inflammation/Sty Yes___ No___
Name and Address of Eye Doctor_____

Does the student have any allergies? Yes____ No____ Been Prescribed an epi-pen? Yes__ No__
If yes, please explain_____

Does the student take any medications regularly? Yes____ No____ Medication Name(s)_____
Will he/she need medication during the school day? Yes_____ No____ Reason_____

Is the student currently under professional medical care for any condition?_____
_____

Signature of parent/guardian:_____Date:_____