

**WEBB CITY R-7 SCHOOL DISTRICT
2018-2019 HEALTH INFORMATION
K – 8th Grade Form**

Name _____ Mother _____

Birthdate _____ Father _____

Boy _____ Girl _____ Lives with _____

Grade _____ Has your child attended Webb City Schools before? _____

Health information will be shared with the school staff on a need to know basis. In case of an emergency, the student may be transported by medical emergency services.

Signature of legal Parent/Guardian _____ **Date** _____

COMPLETE THE FOLLOWING REGARDING HEALTH CONCERNS THAT PERTAIN TO YOUR CHILD

Allergies No ___ Yes ___ To drugs, food, insects, seasonal? Please list: _____
Has the allergy required emergency action in the past? No ___ Yes ___

Asthma No ___ Yes ___ Triggered
by: _____ Treatments _____
Diagnosed by
Dr. _____ Date _____

Diabetes No ___ Yes ___ Takes insulin? No ___ Yes ___ Date diagnosed _____

Epilepsy/Seizures No ___ Yes ___ Absence Seizure? _____ Grand Mal Seizure? _____
Date of last seizure _____ Medication? _____

Heart Condition No ___ Yes ___ Describe _____
Any physical restrictions? _____ Medication? _____

Bone or joint problems No ___ Yes ___ Describe _____
Any physical restrictions? _____

Eye problems No ___ Yes ___ glasses? _____ contacts? _____ lazy eye? _____

Ear problems No ___ Yes ___ frequent infections? _____ tubes? _____ presently ___ past ___
hearing loss? Rt ___ Lt ___ hearing aid? _____

Serious injuries No ___ Yes ___ Describe _____

Surgeries No ___ Yes ___ Describe _____

Chickenpox No ___ Yes ___ Date of disease _____ (Must have physician signature to verify.)

Other Health Problems No ___ Yes ___ Describe _____

MEDICATION

	No ___ Yes ___	<u>**Name of Medication**</u>	<u>**Reason for taking**</u>
Takes at school	No ___ Yes ___	_____	_____
Takes at home	No ___ Yes ___	_____	_____
		_____	_____