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?_____________________________
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Signature of parent/guardian:____Date:_______________