NEW STUDENT MEDICAL RECORD

WISCONSIN RAPIDS PUBLIC SCHOOLS

This information will be shared with appropriate school personnel only.

Student Name:______________________________Gender: M / F Birth Date: ____________ Age: ____Grade____

Parent/Legal Guardian: ____

Address: ___________________________________ City:__________________________ State:_____ ZIP:_________

Phone number: ____

Family Physician: ____ Copy of Immunizations: ☐Yes ☐ No

Does your child take prescribed medication? ☐Yes ☐ No If Yes…☐Taken At Home ☐Taken At School

What medication: ____

What for: ____

MEDICAL HISTORY (check items child has had)

Arthritis	_____	Chicken Pox	_____	High Blood Pressure	_____
Asthma	_____	Diabetes	_____	Premature Birth	_____
Attention Deficit Disorder	_____	Ear Infections (chronic)	_____	Traumatic Brain Injury	_____
Bladder/Kidney Infection	_____	Epilepsy	_____		
Blood Disorder	_____	Emotional/Mental Illness	_____		
Bowel Problems	_____	Heart Disease/Defect	_____		

Additional Information ____

Vision Problem (explain) ____

Does your child wear glasses? Yes _____ No _____

Hearing Problem (explain) ____

Allergies

Medication:____

Food: ____

Animal/Insect: ____

Seasonal: ____

Does your child require an EpiPen? Yes _____ No _____ Antihistamine (Benadryl) Yes _____ No ____________________

Serious accidents: ____

Operations (what and when): ____

Are there any special medical or other concerns that the school should be aware of to enable us to design an educational program for your child? ____

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Are there any health conditions regarding your child that you would like to discuss with the school nurse? Yes ___ No ___

(For Kindergarten Only) Is your child toilet trained? Yes _____ No _____

____ ____________________

Parent Signature Date