

**Dodgeville School District
Student Health Information and**

School Year _____

Authorization for Emergency Medical Treatment

Dodgeville School District appreciates your help in updating your child's health and emergency information each school year so that staff can take the best possible care of him/her at school. Please fill out this information sheet, sign and return it to school immediately. For special problems or concerns please contact the school nurse after completing the form.

Student's Name _____ Birth Date _____ Sex _____ School _____ Grade _____

Family Doctor/Clinic/ _____ Town/Phone Number _____

STUDENT MEDICAL HISTORY: Please Check all that apply to this student

No Health Concerns	No Known Allergies	
Asthma within last 3 years	Allergic reaction requiring CARE	Heart Condition (Explain Below)
Uses inhaler	Child Uses Epipen for Allergy	Uses wheelchair
Frequent headaches	Plant Allergies / Hay fever / Seasonal	Cerebral Palsy
Migraine Headache	Food Allergy _____	Cystic Fibrosis
Diabetes	Drug Allergy _____	Chickenpox Date: _____
Uses Insulin / Insulin Pump	Animal Allergy	Unresolved Injury (Explain Below)
Glucagon for low blood sugar	Bee or Insect Sting needs Medication	Tuberculin test positive or treated
Convulsions/ seizures/ Epilepsy	Other Allergy (Explain Below)	Vision Problem or Loss
Uses Diastat for seizure	Frequent nosebleeds	Wears Glasses at all times
Mental health problem (Explain Below)	Frequent earaches, infections, colds	Wears Glasses to read only
Depression	Eczema/skin trouble	Wears Contact Lenses
ADD/ADHD (select one)	History of Concussion or Head Injury	Color vision impaired
Anxiety	Speech problem	Red/Green Blue/Yellow ALL
Autism	Hearing problem or loss	Wears braces or retainers on teeth
Constipation	Wears Hearing Aids Left Right	Physical defects (List Below)
Crohn's Disease	Scoliosis	Other Health Condition (Explain Below)
Irritable Bowel	Kidney or bladder trouble	

Please explain special health problems: _____

ALLERGIES:

Please describe the item allergic to, the allergic reaction and treatment; Epipen Antihistamine or Benadryl

Do your child's health problems affect his/her daily living or school participation: YES NO *If YES, please explain:*

List and give any significant, injuries, deformities or operations: _____

Is child required to take medication or treatments regularly either at home at school? YES NO

If YES, please list medications & reason for taking:

List any special needs for riding school bus: _____

I understand that the medical information provided above will be shared, if indicated, with those who need to know in order to provide a safe environment for my child.

Signature of parent/guardian

Date

Contact Phone Number

Student Health Care Authorizations _____

Student's Name _____ Birth Date _____ Sex _____ Grade _____

Wisconsin Immunization Registry (check one)

_____ I authorize Dodgeville School District to release immunization information concerning my student to the Wisconsin Immunization Registry (WIR) and my child's medical provider. WIR allows this information to be accessed securely by health care providers and assists in maintaining a complete and accurate immunization record for the child.
_____ I do NOT authorize Dodgeville School District to release immunization information concerning my student to the Wisconsin Immunization Registry (WIR).

Student Screening

The Dodgeville School District routinely screens student's vision, hearing, height and weight at school. This information is kept confidential. If you do not want your child screened, please contact the school district nurse **in writing** with that information.

Emergency Medical or Dental Treatment (check one)

_____ I authorize the principal or his/her designee to transport and seek emergency medical or dental treatment when the need for such treatment is immediate and when efforts to contact me are unsuccessful. This authorization shall remain effective for the full school year and school related summer activities unless revoked in writing and delivered to the Dodgeville School District. I understand that the Dodgeville School District, its employees and its Board of Directors assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of EMS transportation, hospitalization, examination, x-ray, or treatment provided in relation to this authorization shall be my responsibility.

_____ I do NOT authorize or consent to emergency medical or dental treatment for my child. Please relate the procedure to follow if the child has problems, until the parent can be contacted: _____

Human Growth & Development and Puberty Education for 4th & 5th grades

The Dodgeville School District routinely teaches 4th and 5th grade students about human growth and development including puberty education and personal hygiene. All students will be included in these classes unless the parent or guardian notifies the school **in writing** that their student should not participate in this class. Information about what is taught in the class is available and should be requested from the school nurse.

I understand that the medical information provided above will be shared, if indicated, with those who need to know in order to provide a safe environment for my child.

Signature of parent/guardian

Date

Contact Phone Number