

Wapahani High School
2009-2010
Health Records

Students Name _____ Grade _____ Age _____
Siblings Names _____ Age _____ School _____

Check if student has had problems with any of the following:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Asthma (diagnosed) | Last Tetanus received _____ yr. |
| <input type="checkbox"/> Nose bleeds | Chicken Pox Disease _____ yr. |
| <input type="checkbox"/> Head injuries (History of) | Chicken Pox shot _____ yr. |
| <input type="checkbox"/> Diabetes (Diagnosed) | Receives Flu shot annually _____ |
| <input type="checkbox"/> Seizures (History of) | Any additional immunizations: |
| <input type="checkbox"/> Frequent Headaches | _____ |
| <input type="checkbox"/> ADHD (Diagnosed) | _____ |
| <input type="checkbox"/> Other | |
| <input type="checkbox"/> Allergies (please list) _____ | |

Please explain any serious illness or injuries: _____

Does participation in sports or PE aggravate any existing conditions? Please explain:

Medication Permission

If my child experiences discomfort throughout the school day they are allowed to have the following medication: (Please check ones that apply)

Tylenol 325 mg tablet _____

Ibuprophen 200 mg tablet _____

I understand that I will be notified if my child has taken up to three doses in a week's period by the nurse. My child is not allergic to Tylenol or Ibuprofen.

Parent/Guardian Signature _____

Emergency Medical Authorization Permit

In case of accident or serious illness, I request the school to contact me. If the school officials are unable to contact me, I hereby authorize the school to telephone the physician indicated below and to follow his/her instructions. If it is not possible to contact the physician, the school may make whatever arrangements necessary.

Parent Signature _____

Phone number to reach parent during school hours _____

Cell phone of parent if applicable _____

Doctor Preferred: _____ Phone _____

Additional Emergency Contact Name: _____ Phone _____
