

WESTERN DUBUQUE CSD SUPPLEMENTAL HEALTH REPORT

STUDENT INFORMATION:

Last Name: _____ First Name: _____
 School Building: _____ School Year: 20 - 20
 Grade: _____ Birth date: _____ Home Phone #: _____
 Father/Guardian Cell #: _____ Mother/Guardian Cell #: _____
 Home Address (include PO Box): _____ City: _____
 Father/Guardian (with whom student lives): _____
 Father/Guardian's Workplace: _____ Work Phone #: _____
 Father/Guardian's e-mail address: _____
 Mother/Guardian (with whom student lives): _____
 Mother/Guardian's Workplace: _____ Work Phone #: _____
 Mother/Guardian's e-mail address: _____

MEDICAL INFORMATION:

Family Doctor: _____ Phone #: _____
 Family Dentist: _____ Phone #: _____
 Hospital Preference: _____
 Medical Insurance: Blue Cross HMO John Deere SISCO Medicaid/Title XIX HAWK-I
 Other/Please specify: _____
 Booster Immunizations (within the past year): _____ Tetanus _____ MMR
 (Date) (Date)

Does this student have: (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Eyeglasses and/or <input type="checkbox"/> Contacts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Problem | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Joint Problem | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Attention Deficit/Hyperactive Dis. | <input type="checkbox"/> Frequent Headaches |
| | | <input type="checkbox"/> Hearing Problem |

Please list any other health conditions or chronic health problems that we should be aware of that may interfere with educational programs or activities:

Is medication taken regularly? No Yes If yes, what for? _____

Name of medication: _____ Dosage: _____ Time: _____

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The school nurse has my permission to share the above information with those who need to know? Yes No

If you cannot be reached for an illness/injury, who should be called?

Name: _____ Phone #: _____

Address: _____ City: _____

Parent/Guardian signature

Date

RETURN THIS FORM TO SCHOOL OFFICE BEFORE SEPTEMBER 1ST.