WESTWOOD PUBLIC SCHOOLS
Westwood, Massachusetts

STUDENT HEALTH INFORMATION

Student Name: ________________________ Date of Birth: ________________

Gender: ________ Grade: ________ Health Care Provider: ____________________

Type of Medical Insurance:
❑ Private ❑ MassHealth ❑ Military ❑ Children's Medical Security Plan ❑ None
❑ Other: ______________________________

Medical History (check the ones that apply to your child):

❑ ADD/ADHD	❑ Dental Problem	❑ Menstrual Problem
❑ Alcohol/Drug Misuse	❑ Eczema	❑ Muscle Disorder
❑ Anorexia/Bulimia	❑ Fainting Spells	❑ Neurological Disorder
❑ Anxiety/Panic Attacks	❑ Frequent Earaches/Infections	❑ Orthopedic Condition
❑ Asthma	❑ Headaches	❑ Seizures
❑ Bleeding Disorder	❑ Hearing Problem	❑ Speech Problem
❑ Color Blindness	❑ Heart Condition	❑ Toileting Difficulties
❑ Diabetes	❑ Kidney/Bladder Problem	❑ Vision Problem

If you have checked any of the above, please explain and give dates:

____

Allergies: ❑ Plants ❑ Foods ❑ Bees or Insects ❑ Animals ❑ Medication: ________

❑ Other: ____

Is medication needed for any condition: at home? ❑ Yes ❑ No at school? ❑ Yes ❑ No

Name of medication: ______________________________ Dosage: __________

Reason needed: ____

List any operations, injuries, hospitalization or prolonged illness and give dates:

____

List any past or current mental health concerns:

____

Recommended Physical Activity (please check one):
❑ Full Activity/Sports ❑ Modified/Restricted Activities ❑ If restrictions, please explain:

____

Does your son/daughter wear glasses? ❑ Yes ❑ No Contact lenses? ❑ Yes ❑ No

Is your child receiving any outside services (counseling, speech, physical therapy, tutoring, etc.)?

____

Is there anything you can tell us about your son/daughter that you feel will help the school staff to better understand and work with him/her?

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Please contact the school nurse if your child has a serious medical condition or if you have any questions or concerns.

Parent/Guardian Signature: ______________________________ Date: ____________